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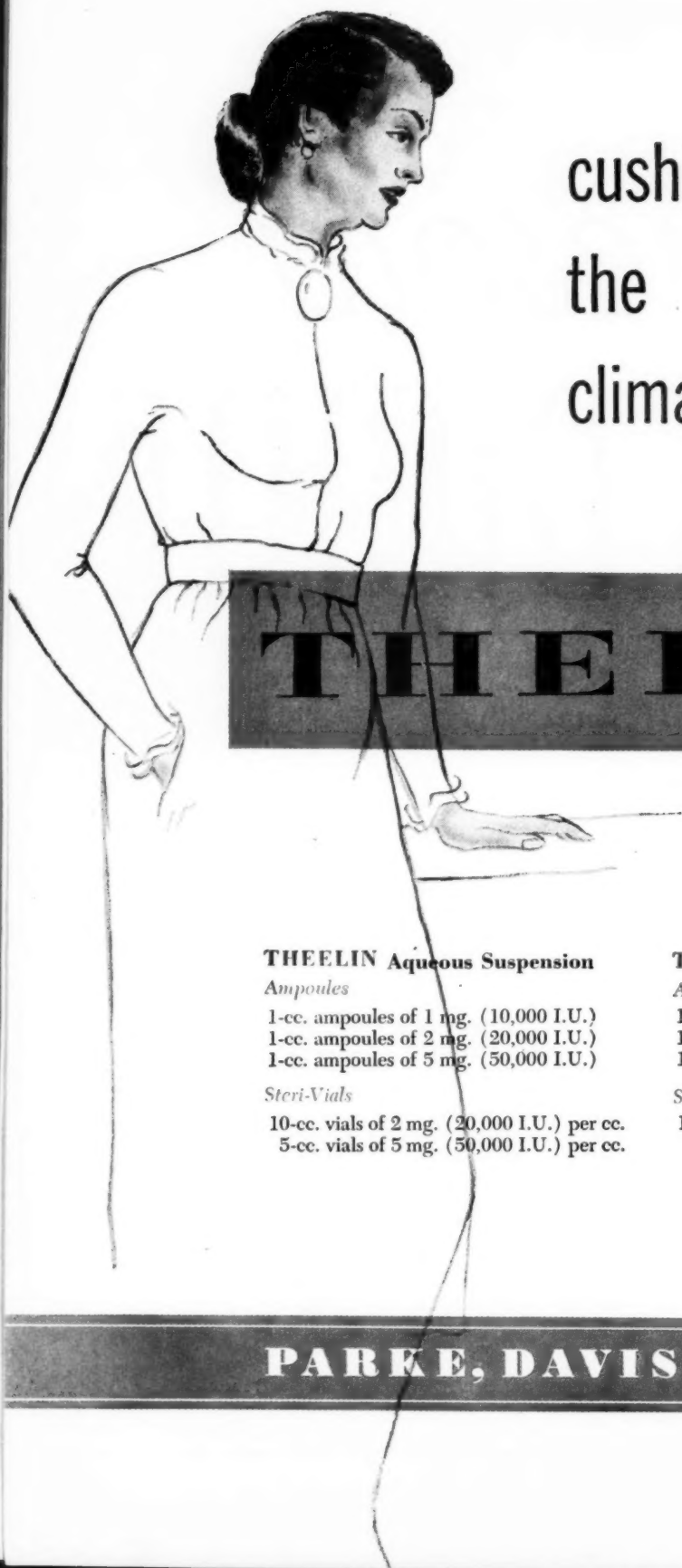
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Minnesota Medicine

Journal of the Minnesota State Medical Association, Southern Minnesota Medical Association, Northern Minnesota Medical Association, Minnesota Academy of Medicine and Minneapolis Surgical Society

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A MATERNAL SYNDROME ASSOCIATED WITH ISOIMMUNIZATION AND FETAL DEATH IN UTERO

IRWIN H. KAISER, M.D.

Minneapolis, Minnesota

THE fate of the fetus, rather than that of the mother, has up to now commanded attention in pregnancy complicated by isoimmunization. Except for the occasional sensitized mother brought to clinical notice by mismatched blood transfusion or afibrinogenemia,⁵ it has been generally assumed that isoimmunization produces no recognizable symptoms and that laboratory determination of circulating antibodies is required for its recognition. Recent editions of two standard obstetrical textbooks either state that no clinical disease in the mother has been correlated with isoimmunization² or indicate that perhaps the incidence of toxemia is slightly increased.³

The three cases reported below represent instances of a striking maternal syndrome associated with grave degrees of isoimmunization. It is noteworthy that each patient presented herself to the physician with specific complaints. Both patients who had had previous fetal death in utero stated simply that they were experiencing a repetition of complaints associated with that event. The common clinical features in these three patients are a history of previous infant mortality due to erythroblastosis fetalis, the presence of high anti-Rh antibody titers, the sudden appearance prior to term of mild generalized and moderate dependent edema with sharp weight gain and the destruction of the fetus in utero shortly thereafter.

Case 1.—Mrs. H. L., a twenty-six-year-old woman, para 3-0-0-1, registered for the first time at Sinai Hos-

pital, Baltimore, Maryland, on June 24, 1949, with an expected date of confinement of November 12, 1949.

In 1945 she had delivered elsewhere a baby which was in excellent condition at birth and which is alive and well today. In 1946 the patient was delivered at the same hospital of a living male infant. An abstract from that hospital stated that the baby was born without difficulty but almost immediately after birth began showing signs of abnormality. It had a weak cry and was noted to be markedly jaundiced. A diagnosis of erythroblastosis fetalis was made, and despite transfusion with Rh-negative blood, the baby expired. In the third pregnancy, which terminated in 1948, fetal movements ceased one week prior to delivery, which occurred three weeks prior to term. The infant weighed 8 pounds 2 ounces, but the only information that could be obtained from the hospital was that "the baby died before birth because of Rh-negative factor."

The patient gave no history of transfusion.

Examination of the patient's blood disclosed that she was blood group A₁ MN, Rh negative (cde). Antibody titers had been studied in the previous pregnancy and were elevated throughout that pregnancy. At the time of initial examination during the present pregnancy, elevated anti-Rh titers were again found. The patient's husband was found to be blood Group O Rh₀ (cDe). The husband's father was found to be an A₁ MN, Rh₂ (cDE), and the husband's sister, A₁ MN Rh₂ (cDE). The husband's mother was dead. It was, therefore, not possible to prove that the husband was homozygous.

Treatment with Rh haptene (Lilly) was initiated on August 2. Haptene was given once a week throughout August. There was no change in antititers. In the first week in September it was reported that the antititers had suddenly markedly increased. A few days after this observation the patient reported to the obstetrical clinic. She stated that fetal movements had suddenly become less and that the same pattern which had preceded her last fetal death in utero was appearing. The patient herself had noticed that two days previously she had begun to have edema in the lower extremities. She had increased 5 pounds in weight, from 100 to 105 pounds in

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ISOIMMUNIZATION AND FETAL DEATH—KAISER

five days. There was no albumin of the urine. Blood pressure was 95/60. Despite the fact that the patient was two months from term, the fetus was estimated to weigh 2,600 grams. The fetal heartbeat was heard. X-ray of the abdomen was taken and was interpreted as showing slight edema of the fetal scalp. Epiphyseal centers were not found in the fetus. The patient was seen again a few days later, stating that she had felt no fetal movements for four days, and the fetal heart could not be heard at this time. However, the marked edema of the patient's feet and ankles was still present and the patient's face appeared pasty. She stated that she thought it was swollen. Her weight had increased another 2 pounds. About two weeks later the patient rather suddenly began to feel much better. Edema disappeared and she had a weight loss of 6 pounds, down now to almost the same weight she had been prior to the beginning of the episode. However, her appetite was poor.

She was followed for another week and a half, and finally on October 11, approximately four weeks following fetal death, the patient went into active labor. She delivered a macerated stillborn male infant weighing 1,700 grams without event. The post-partum course was entirely unremarkable.

Case 2.—Mrs. H. M., a thirty-year-old woman, para 2-1-0-1, registered for the first time at University Hospitals on October 31, 1950, with an expected date of confinement of April 26, 1951.

In 1942 she had a term delivery by low forceps of a 7-pound baby in excellent condition. Her second delivery in 1946 terminated spontaneously at thirty-eight weeks in the birth of a stillborn infant which weighed approximately 6½ pounds. She had noticed decreased fetal movements in the last weeks of pregnancy. About two weeks prior to the termination of this second pregnancy, the patient developed a deep burning itch of the hands and feet which vanished at the time of delivery. In 1949, at seven and one-half months of pregnancy, she spontaneously delivered a stillborn infant weighing approximately 5 pounds, which had had decreased fetal movements a few hours before labor began. With this third pregnancy, she had noticed itching of her hands, feet and other parts of the body which began three weeks prior to fetal death in utero.

The patient gave no history of operation or blood transfusion.

Laboratory studies revealed that the patient was Rh-negative (cde). Her husband was found to be Rh₂ (cDE) and hr" (e) negative. Her living child was found to be Rh₂ (cDE) hr" (e) positive. Her blood, titrated against Rh₀ (D) cells, revealed no anti-Rh₀ (anti-D) antibodies. However, when it was titrated against Rh" (E) cells, high titers were found.

She was begun on Rh haptene (Lilly) in early November. Titers taken on blood in the last week of December showed marked increase in all the titers. The pregnancy proceeded uneventfully until January 6, when the patient noted the onset of itching of the palms and soles. She was seen very shortly after this. Physical examination was entirely unremarkable. The pregnancy

seemed to be proceeding uneventfully. There was no albumin in the urine. The fetal heart beat was excellent in the left lower quadrant, and the patient had noticed no change in fetal movements. She was at this time approximately twenty-five weeks' pregnant. Haptene therapy was continued. On January 16 it was noted that the uterus seemed to be enlarging very rapidly. The patient was steadily gaining weight during this period. Fetal heart tones were good and fetal movements excellent. The itching continued without change. On January 20 there was a sudden exacerbation of the itching. She had gained 15 pounds in weight from 138 to 153 in the three weeks since the end of December. Fetal movements were felt the previous night, but none felt that day. It was difficult to be certain of the presence of fetal heart tones. The patient was given a prescription for phenobarbital and pyribenzamine on empiric grounds and two days later reported that the itching was much relieved. However, she had had no fetal movements in the last two days. In the last week in January the patient suddenly noted considerable swelling of the feet and ankles which lasted for about two days and was accompanied by a further gain in weight of several pounds. Study of the serum bile acids at the height of the itching on January 23 revealed a level of 1.3 mg. per cent against a control value of 0.8 mg. per cent.

The patient had three episodes of false labor. She was finally brought into the hospital on February 7, at which time she was essentially asymptomatic except for some brownish discharge. She had just lost 10 pounds. Induction was carried out successfully with the delivery of a 950 gm. stillborn infant. The placenta, which was obviously severely involved in hydrops fetalis, weighed 935 gm. and its delivery was accompanied by a 750 cc. third-stage hemorrhage. The patient was given a 500 cc. blood transfusion. Serum bilirubin done on the third day was 1.0 mg. per cent in one minute, 1.6 mg. per cent total. The patient's puerperium was entirely uneventful. She was discharged from the hospital asymptomatic and in good emotional state.

Case 3.—Mrs. L. S., a twenty-four-year-old woman, para 3-0-0-2, registered for the first time at University Hospitals on May 31, 1951, with an expected date of confinement of October 8, 1951.

In 1944 she gave birth spontaneously at full-term to an infant weighing 7 pounds 15 ounces without event. In 1945 she gave birth after an eight-hour labor to an infant weighing slightly over 9 pounds. These infants are living and well. She is said to have had a considerable amount of hemorrhage after each delivery, but it is not known definitely whether she had blood transfusion. In 1950 a term pregnancy which was complicated by elevated blood pressure and considerable edema terminated in the delivery of twins. One infant was noted to be jaundiced at birth and became worse very rapidly. Despite transfusion it died within forty-eight hours of delivery. The other infant was not noted to be jaundiced at birth, but it had a rapid drop in hemoglobin with an abnormal number of erythroblasts present in the blood, and despite an exchange transfusion done on the

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third day of life, the baby died on that day. Autopsy was performed on both infants and reported to be compatible with erythroblastosis.

The fact that the patient was Rh-negative was not ascertained until after this delivery.

Her living children were both found to be Rh₁ (CDe). Her husband was also an Rh₁ (CDe) homozygous for Rh' (C).

The patient was found to have markedly elevated Rh antibodies on admission. She was followed in the out-patient department for the next several months. The fetal heart tones were first heard at the end of June. The patient received no therapy. She gained weight slowly to reach 250 pounds at the beginning of August. When she was seen in the out-patient department on August 23, approximately thirty-two weeks' pregnant, she was noted to have had a 5-pound weight gain. Blood pressure was still entirely normal and there was no albumin in the urine. Two weeks later, on September 6, 1951, the patient was found to have gained 15 pounds in the preceding two weeks. Fetal heart tones were present. There was a trace of albumin in the urine and blood pressure was within normal limits. Antibody titers had not changed materially. Hospitalization was advised, but the patient refused.

The patient appeared at the hospital at 5:00 a.m. on September 9 because of a sudden exacerbation during the night of severe generalized itching, which had appeared on September 6 but continued to get much worse. She had also had aching in the pelvis, nausea, a little bit of vomiting and generalized malaise. Examination of the urine disclosed 1+ albumin. Because of the patient's marked obesity, it was difficult to make out fetal size but the impression was that the baby was large. Fetal heart tones were present. Blood pressure on admission was 150/100. The situation was reviewed, and it was felt that fetal death in utero was imminent. It did not seem advisable to induce labor since the presenting part was floating and the cervix long and closed. It was, therefore, decided to terminate the pregnancy by cesarean section in an attempt to get a living baby. This procedure was carried out, with the delivery of a massively edematous, stillborn, 3,000 gm. infant with bilateral hydrothorax, ascites, generalized edema and a hemoglobin on the heart's blood of 3.6 gm. per cent. The serum proteins were found to be 1.8 gm. per cent. Autopsy on the infant was refused. The placenta was massive and showed the characteristic changes of hydrops fetalis.

In the twenty-four hours following delivery, the patient had a spectacular elevation of blood pressure which reached at its maximum a level of 220/150. This responded well to sedation and the patient at time of discharge had stabilized her blood pressure at 140/90. Examination of the eye grounds showed generalized arterial spasm with old choroiditis in the left eye in a patch of considerable size. The vascular spasm persisted for the entire hospital course. However, the albumin in the urine disappeared very rapidly after delivery and within twenty-four hours was absent. Study of the patient's circulating bile acids immediately prior to operation revealed a level of 1.5 mg. per cent against

a control of 0.82 mg. per cent. The patient's bilirubin was entirely normal, producing an immediate reading of 0.1 mg. and a late reading of 0.3 mg. Pruritus disappeared almost immediately after delivery and did not reappear. The puerperium was otherwise uneventful.

Discussion

E. L. Potter, in her book on Rh, makes reference to a maternal syndrome associated with isoimmunization as follows:

"There is a small group of women, however, who give birth to infants with hemolytic disease who show symptoms simulating toxemia but in whom the condition appears to be specifically related to the existence of hemolytic disease. In these patients pregnancy usually progresses normally until the seventh or eighth month, and then a sudden rapid increase in weight is associated with visible edema. A moderate amount of albumin is usually excreted in the urine. The systolic blood pressure almost never rises above 140. The fetus ordinarily dies soon after the onset of symptoms and is retained for varying lengths of time before it is delivered. We have not observed this syndrome in our series except in women who have previously delivered at least one other child with hemolytic disease."⁴

There can be little doubt that the three patients described above fall into this group. Mrs. H. L., the first of the three, fitted Potter's description exactly. Mrs. H. M., the second, while meeting all the other criteria, presented a new complaint. This pruritus, which was so persistent and which, the patient herself was convinced, foreshadowed the death of the fetus in utero, was never satisfactorily explained. The third patient in turn presented all these findings, and in addition, subsequently developed manifestations indistinguishable from severe acute toxemia of pregnancy.

The determinations of blood bile acids must be presented without comment. Although they were obtained in the search for a cause of the itching, there is no information as to normal or abnormal control values in pregnancy by the same method with which to compare them. The determinations of serum bilirubin make it appear unlikely that the itching is associated with jaundice.

It is certain that these are not the ordinary events of fetal death in utero. No such syndrome has been described in association with fetal death due to other causes,¹ and in patients with severe isoimmunization and fetal death in utero, the latter event ordinarily occurs in complete clinical silence. On the other hand, the observation of the present cases in a small group of sensitized wom-

(Continued on Page 31)

FETAL SALVAGE IN PREGNANT DIABETIC PATIENTS

T. PETRICK, M.D.

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AS in all obstetrical problems in recent years, the question of maternal mortality has largely been pushed further and further into the background due to improved techniques for assuring maternal survival. The result has been an emphasis upon the search for methods of increasing fetal salvage. Because the survival rate for babies of diabetic mothers is known to be low, this field has produced extensive investigation and argument. The question resolves itself into three main points for purposes of exploration:

1. Control of the maternal diabetes.
2. Maintenance of intra-uterine life and delivery of living infant.
3. Survival of the infant in the neonatal period.

The first lies largely within the province of the internist. No attempt will be made to outline the problems of diabetic management. This, however, is of utmost importance to the fetus, as has been shown by many workers. Priscilla White¹ in 1943 said that "acidosis *per se* is not important as a lethal factor in producing fetal death." This has not been the experience of recent investigators. Hall and Tillman² have shown that the reverse is true. In their series of nine pregnancies exhibiting acidosis, six resulted in the loss of the fetus within a few days of the episode of acidosis. Although this is a small group, it has been the experience of others. For example, at the Charles T. Miller Hospital in a period of five years, eleven patients in acidosis at one time or another throughout their pregnancies produced only three living infants who survived the neonatal period.

Unregulated, brittle diabetics, because of known vascular changes, are believed to be more prone to all types of toxemia of pregnancy. This factor is responsible for an even lower fetal survival rate. To further emphasize the point, patients whose diabetes is under careful control have an incidence of toxemia reported to be between 30

and 50 per cent. In one notable exception, Reis³ has reported a group of fifty-two diabetic women having seventy-two pregnancies, in which there were only six cases of toxemia. His group, however, contained very few patients having juvenile diabetes, or any patients whose diabetes occurred before the childbearing period. This would emphasize the point that patients with long-standing diabetes are more liable to have the antecedent vascular changes which predispose their type to toxemia. The most careful control and management is necessary throughout pregnancy in these patients to hope for a successful outcome.

Our second point, the maintenance of intra-uterine life to a point where fetal survival can be expected, is also intimately connected with the previous problems. A new approach to the problem was suggested by Smith and Smith.⁴ It was their opinion that the administration of estrogenic substances during the course of a pregnancy increased the fetal survival. A further step in the right direction seemed to be taken when White¹ reported her studies on the "hormonal imbalance" of diabetic pregnancies and the possibilities of using stilbesterol to correct them. Over a period of fifteen years she reported 439 viable births with a fetal mortality of 18 per cent. These cases were subdivided into three groups: (1) Eighty-four cases with "abnormal hormone values which could not be corrected," (2) 297 cases with "abnormal values which were corrected," (3) Forty-seven cases with normal hormone values.

The fetal mortality rates for the groups were 42, 11 and 5 per cent, respectively. This work seemed to demonstrate once and for all that, in diabetics, with the use of stilbesterol, a definite and marked improvement could be obtained in fetal survival.

With the passage of time, certain inconsistencies have developed, and other contradictory evidence has been presented. Reis,³ in 1950, reporting on his series previously mentioned, had a comparable viable birth mortality rate of 13.6 per cent, without the use of stilbesterol. Hall and Tillman² reported a fetal mortality of 18.2 per cent in diabetic mothers cared for at the Sloane Hospital for Women in New York City from

Read at the general staff meeting of the Charles T. Miller Hospital, Saint Paul, November 6, 1951.

Dr. Petrick is resident in obstetrics and gynecology at Charles T. Miller Hospital.

1923 to 1949. This mortality rate was also obtained without the use of stilbesterol.

It would seem pertinent at this point to quote directly from Reis' article:

"The administration of stilbesterol in increasing daily doses is presumed to stimulate progesterone secretion, thus restoring the normal hormone balance and preventing immature and premature labor and toxemia of pregnancy. Recently Smith and Smith have shown that the administration of stilbesterol to normal, non-diabetic women resulted in larger, longer, heavier and more mature babies, with a definite decrease in the incidence of prematurity.

"Sommers, Lawley and Hertig investigated the effects of this same stilbesterol therapy upon the weights of baby and placenta in the same group of women. They stated that 'weight of both baby and placenta are increased in stilbesterol-treated full-term and premature births' and that 'stilbesterol stimulates an increase in weight and presumably size of both infant and placenta.' They further found 'a more frequent occurrence of marked placental calcification and intervillous thrombosis in full-term stilbesterol-treated placentas and a definite incidence of mature chorionic villi and intervillous thrombi in the placentas of stilbesterol-treated patients who delivered prematurely.'"

He further states:

"It is difficult to reconcile these reports. On the one hand, increasing and continuing administration of stilbesterol is used because it prevents immature and premature delivery, because it lowers toxemia, and, finally, because it is said to increase fetal salvage. Yet, in White's report, labor was terminated early in the vast majority of instances by cesarean section in the thirty-sixth to thirty-seventh weeks to prevent fetal overmaturation and placental overmaturation with their accompanying obstetrical problems of oversize and overweight fetuses and of fetal death in utero. On the other hand, the same increasing and continuing administration of stilbesterol is observed by Smith and Smith to result in larger, longer, heavier, more mature babies.

"Furthermore, stilbesterol therapy would seem to be contraindicated in the diabetic, pregnant women to avoid rapid and early senescence of the placenta and to prevent some of the inexplicable fetal deaths in utero which are known to occur in the later weeks of pregnancy.

"Further confusion concerning this entire problem results from a recent report by Davis and Fugo, who could find no evidence that stilbesterol stimulates production of steroid by the corpus luteum or the syncytium."

In the light of this, it is sufficient to say that our small series of twenty-six pregnancies in seventeen patients at the Miller Hospital had a fetal salvage almost exactly the same whether treated with stilbesterol or not. If any trend is apparent

in our series, it would seem that the patient not receiving stilbesterol had a better chance to obtain a surviving infant.

With these things in mind, it would appear that the reasons originally proposed to validate the use of stilbesterol have not been borne out by either experimental evidence or improved fetal survival. Study of the literature, together with an analysis of our own experience, justifies the opinion that the administration of stilbesterol in the pregnant diabetic woman, as recommended by Smith and Smith,³ offers little or nothing at all toward an improvement in fetal survival.

This opinion does not dismiss the well-known fact that infants of diabetic mothers have the unexplained propensity to expire *in utero*. Since this disaster tends to occur more frequently after the thirty-fifth week of gestation, the question arises as to the exact etiology. Is it due to the diabetes *per se*? Is it due to a greater incidence of toxemia? Further, if the infant survives to the point of parturition, is the poor fetal survival due to the tendency for infants to be greatly oversized, with resultant traumatic deliveries? With these thoughts in mind, it is understandable that many obstetricians believe that the fetal survival can be improved by delivery several weeks before term. There is fairly universal disagreement as to when and how the delivery should be accomplished.

In any obstetrical problem, there can be no absolute and set policy in the management of all patients. The number of variable factors, especially in pregnant diabetics, is too great to permit the establishment of an inflexible rule.

The proposal of one group, such as White's, to section almost all patients a month before term, falls into such an inflexible category, ignoring as it does the possibilities of medical or surgical induction of labor in the proper patients as an alternative. White, in her series of 439 viable births, sectioned 75 per cent of her patients at about thirty-six weeks, for a fetal survival of 82 per cent. One-half of the fetal losses in this series, however, were in the neonatal period, indicating that prematurity may have played a large part in the failure of the infant to survive. Hall and Tillman reported 104 viable births with a fetal survival of 81.8 per cent. In this series only one patient in five was sectioned and then only for obstetrical indications. Only 10 per cent of their fetal losses were in the neonatal period. In a com-

parison of the two series, Hall and Tillman came to the conclusion that if they had sectioned fifty more patients according to the plan of White's they might have obtained five more living infants. Reis, in reporting his seventy-two viable births, sectioned about one-half of his patients. All of these section infants survived and the great majority of these operations were done at the thirty-sixth to thirty-eighth week.

On the basis of what has just been said, it would seem that a definite criterion can be established for the chance of delivering a living and surviving infant. One must deliver the infant by section or induction of labor before fetal death *in utero*. Since it is impossible to determine just when this catastrophe will occur in any given patient, the choice of the time and type of interference must be left to the obstetrician in charge.

The actual choice of the procedure for the individual case will depend upon physical findings, keeping in mind the added factors of toxemia and uncontrollable diabetes. The use of cesarean section at the thirty-sixth week enjoys the most universal popularity. This procedure, however, must only be done after the diabetes is well regulated. It would seem to us that the solution of this particular problem can be outlined in the following manner.

If the patient is a primipara, with what may be an oversized fetus, there is very little question but that the patient is best handled by cesarean section. This is assuming that the danger of delivering a premature child is ruled out by careful estimation of fetal size. It is admitted that the estimation of fetal size is uncertain at best. In the diabetic patient it is made more difficult by the presence of edema and hydramnios.

Cesarean section does not seem justified in patients who are suitable candidates for medical or surgical induction of labor. The indications for these procedures are multiparity, a well effaced and dilatable cervix and a well engaged vertex. Should these conditions be present at the thirty-sixth to thirty-seventh week, one is certainly justified in attempting delivery from below. The question of how to deliver the non-inductible multipara is a difficult one. From our studies we are led to the conclusion that the best course is to resort to cesarean section. When to do the procedure depends upon consideration of the factors previously mentioned.

Twenty-two pregnancies in our series of twenty-

six reached the point of viability or beyond. Thirteen of those patients were delivered from below. In this group there were six stillbirths, two neonatal deaths and five surviving infants for a fetal survival rate of 38.5 per cent. Nine patients were sectioned, seven at thirty-six weeks, resulting in seven surviving infants for a 78 per cent fetal survival rate. This improved survival rate for section infants does not give a true representation of the problem, since all the very premature infants and those that died *in utero* were delivered by the vaginal route. If we eliminate all fetuses delivered or dead *in utero* before the thirty-sixth week, we arrive at a total of nine vaginal deliveries with five surviving infants.

Before discussing the third point of our paper, one interesting and vital point should be made and emphasized. It is now possible to make a flat, uncompromising statement that the incidence of congenital defects is not increased in the infants of diabetic pregnancies. In a survey of the literature in which such material has been reported, plus the cases from our hospital, compromising a total of 257 pregnancies, two major congenital defects were found. Both were forms of congenital heart disease. In addition, there was one case of hypospadias of minor degree. Thus with a maximum total of three congenital defects in 257 cases, the incidence is found to be one in eighty-six, the same figure reported for all normal, non-diabetic pregnancies. This cannot be too strongly emphasized to correct the older, unsubstantiated impression. This is certainly of vital interest to the diabetic patient contemplating pregnancy.

The last point of our paper deals with the survival of the infant in the neonatal period. In this, opinion seems to be fairly unanimous. All infants of diabetic mothers, regardless of size, mode or time of delivery, should be treated as prematures. The routine use of incubation, oxygen, oral or subcutaneous glucose and occasionally gavage seems to be the standard procedure. The difficulty of obtaining statistical evidence in favor of one form of therapy over another is increased by the additional factor of varying degrees of actual prematurity.

Experimental work with micro-sugar determinations shows that those infants have a faster, further drop of blood glucose than do infants of normal, non-diabetic mothers. Also, the return of the blood sugar levels to normal is slower in these

infants than in the normal infants. The need for glucose, whether oral or subcutaneous, is obvious. Since these infants have an active sucking reflex and since they seem to retain oral feedings well, there is often little need for parenteral routes of administration. However, a minimum of fluid is to be used for administration, since some degree of dehydration is useful in treating these often edematous infants.

In summary, one can merely state that the problem of diabetes mellitus complicating pregnancy is serious. The solution to all the problems is not at hand. Improvement in fetal salvage in the diabetic patient demands constant observation, through care and regulation. This can be accom-

plished through vigorous action on the part of the internist, the obstetrician and the pediatrician.

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A MATERNAL SYNDROME ASSOCIATED WITH ISOIMMUNIZATION AND FETAL DEATH IN UTERO

(Continued from Page 27)

en and Potter's prior observation of another group of similar patients make it appear likely that the syndrome is either being overlooked by students of the problem or being classified as an incidental acute toxemia of pregnancy. The symptom of pruritus, which is never associated *per se* with pre-eclamptic toxemia, indicates a definite difference between this syndrome and toxemia. Potter arrived at the conclusion that this is a separate entity without noting any instances of itching.

What is the explanation of this striking maternal hydrops? The data at the moment are inadequate to justify even a guess as to the answer. The edema does not differ from that seen in pregnancy under other circumstances. The most that the present report can hope to do is to stimulate detailed scrutiny of this syndrome, with the expectation that such study may aid in the clinical management of what remains an untreatable group among women with isoimmunization.

Summary

1. Three patients are presented who manifested a maternal syndrome in pregnancy complicated by isoimmunization. The clinical picture is characterized by a history of previously affected in-

fants, appearance in the last trimester of sudden weight gain and manifest edema and subsequent fetal death in utero. Two of the three patients in addition complained of severe generalized pruritus, and one of these developed a severe acute toxemia following delivery.

2. It is suggested that this syndrome, while uncommon, is either being overlooked or being classified as toxemia of pregnancy. Since it appears to be uniquely related to the most severe form of isoimmunization complicating pregnancy, meticulous study of these particular patients is warranted.

3. At present, no explanation of the etiology of the syndrome can be offered.

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POSTPARTUM HEMORRHAGE

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THE subject to be discussed here is one which the majority of physicians have encountered in the past, and can reasonably expect to re-encounter. Eastman, in his textbook, states, "In modern obstetrics, no woman should die from postpartum hemorrhage.³ This is a fair assumption, although no rigid set of rules can be formulated to guard against postpartum hemorrhage in 100 per cent of the patients. It would seem, rather, that certain precautions, together with steadily improving technique and new drugs, may be expected to bring us to an irreducible minimum of casualties.

Postpartum hemorrhage is defined arbitrarily as blood loss in excess of 600 cc. The rate of occurrence is in the neighborhood of 6 per cent, whereas blood loss in excess of 1,500 cc. is seen in about 1.5 per cent. Loss of over 2,000 cc. is present in .07 per cent and fatal hemorrhage occurs in about one delivery in every 3,300 patients. In a recent article, with an analysis of 6,000 deliveries, the average blood loss is reported to be 265 cc. in primiparae and 191 cc. in multiparae.² It was also shown that with episiotomy, or perineal lacerations, an additional average loss of 110 cc. occurs.

Predisposing Causes.—Predisposing causes can be divided into those under the direct control of the physician, and those beyond his control. In the former category are: operative deliveries, in which hemorrhage is three times more common; deep ether anesthesia; prolonged labor with maternal exhaustion; and, finally, mismanagement of the third stage. It has been said that the most common mismanagement of the third stage is in trying to hurry it.¹ In the latter group, that is, beyond the control of the physician, the most important predisposing cause of postpartum hemorrhage is the fetal size. The incidence of hemorrhage definitely increases with large babies, multiple pregnancy, and hydramnios.

Generally speaking, blood loss at levels of 600 cc. is not a serious matter. As mentioned previously, about half this amount is lost in delivery

of an average primipara. It is worthwhile considering that when other conditions of blood loss exist, the loss of an additional 100 cc. or more from an episiotomy may be enough to put the patient into the hemorrhage group. Loss of 1,500 cc. is always a serious matter, and these patients must be carefully attended. An important point is that whereas a patient in good physical condition can withstand a considerable blood loss, another patient who has had an antecedent anemia, or one in whom prolonged labor has produced marked dehydration, may go into shock following the loss of a relatively small quantity of blood.

Etiology.—In order of frequency, the causes of postpartum hemorrhage are uterine atony, responsible for 90 per cent of the incidence; retained placental fragments, to blame in another 6 per cent; and lacerations of the birth canal. Of lesser frequency are rupture of pelvic varicosities, abruptio placentae, and placenta previa.

The first of these, uterine atony, is seen commonly following over-distention of the uterus, such as in the presence of an excessive-sized fetus, multiple pregnancy and hydramnios. Prolonged labor, as in primary and secondary inertia, frequently results in atony. Multiparity is another well-known cause. Fortunately, in all of these cases, the danger is predictable and preparations can be made well in advance in most instances to combat the atony if it develops.

Retention of secundines certainly occurs with great enough frequency to call for routine and careful inspection of the placenta. The finding of a placental defect or evidence of a succenturiate lobe is indication enough to prepare for intra-uterine inspection.

Most perineal lacerations are readily recognized and therefore do not constitute much of a problem. Many authorities suggest cervical inspection following all deliveries, but it is probably enough to undertake inspection only following the operative deliveries. The tears that extend into the fornices are quite dangerous, and even when diagnosed, the repair is one which requires infinite patience and care, with the bloody field and inadequate exposure.

From the Austin Clinic, Austin, Minnesota.

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Clinical Picture.—Postpartum hemorrhage is seldom a massive outpouring of blood, but more often a steady dripping which on occasion may give a feeling of false security. The onset of shock develops commonly only after a period of a few hours, and often with astonishing rapidity. Pulse and blood pressure may compensate nicely for a time and then suddenly the pulse becomes rapid and weak, the pressure difficult to obtain, the patient experiences chilliness and air hunger, and, finally, loss of consciousness may supervene only shortly before death.

Diagnosis.—If bleeding follows completion of the third stage of labor, and if the fundus is firmly contracted, lacerations of the cervix and vagina must be sought for. The color of the blood aids in the diagnosis, with dark, venous blood more likely uterine in origin, and bright red blood probably from lacerations. Inspection of the cervix is definitely required following all operative deliveries. The passage of numerous clots, as well as sudden spurts of bleeding continuing after the fundus has firmly contracted down, will suggest retained placental fragments. Retained fragments plus accumulating clot in themselves may cause atony. In any event, if there is reasonable doubt, preparation for uterine exploration is made.

Once alerted to the possibility of hemorrhage, intravenous fluids are started at once. Cross-matching is carried out. An ampule of ergotrate and one of pitocin are given, the former intravenously. The operator obtains sterile gloves and gown while the perineum is being cleaned and fresh draping is being done. Light ether anesthesia or nitrous oxide will probably be required for exploration of the uterine cavity, though previous anesthesia may preclude the necessity for more. Deep anesthesia is contra-indicated. An assistant keeps up constant massage of the fundus, and, finally, the operator manually examines the uterus and removes any fragments found.

Following this procedure, if bleeding continues, if inspection reveals no lacerations and if the uterus shows no tendency to contract, the operator is forced to make a hasty decision. If shock is not too prominent a feature, if exhaustion and infection are not strong deterrents, and if the parity of the patient does not influence the judgment of the operator, a hysterectomy at this juncture may be a satisfactory solution of the problem. Short of this extreme are two much simpler

alternatives, each with its own advocates. One is intra-uterine tamponade, widely practiced in this country; the other is bimanual compression of the uterus, long an established procedure in England, and steadily gaining adherents in this country. Tamponade, of course, consists of the placing of layer-on-layer of sterile gauze within the uterus, from above downward and with the greatest of caution. The alternate procedure, bimanual compression, is carried out by placing the fist of one hand within the vagina, snugly against the anterior uterine wall, while the other hand, on the abdomen, presses downward to meet the internal hand. This will effectively and immediately control the bleeding and it can be maintained indefinitely. The uterine pack can be used following curettage for incomplete abortion, but the relatively solid wall of a uterus at two to five months' gestation makes a better back-stop than a term uterus, especially one which has been previously distended, or thinned out from many preceding pregnancies, because of the inability of such a uterus to contract when forcibly distended. Those who argue against the pack contend that it is unphysiological, that it predisposes to infection, and that bleeding can actually occur between the pack and the uterine wall.

Finally, it might be well to review the management of the third stage. There is a fairly wide variance of opinion here, and no one technique will serve in all instances. Many favor giving oxytocics immediately after delivery of the head, others after delivery of the shoulder, and still others after delivery of the body. In breach presentations, it is unwise to administer any oxytocic until extraction is completed. Other authorities withhold oxytocics until completion of the third stage.

It is difficult to criticize any of the various methods, each seeming to produce results in the hands of its proponents. When ergotrate is given, it produces better results intravenously and should be given over a period of thirty seconds. If given after the delivery of the head, the attendant should wait for the stimulus to reach the uterus, and allow the contraction to aid in delivery of the body. It is argued that oxytocics employed at this stage speed up the separation of the placenta. It does seem that occasionally a placenta will be trapped by a firmly contracted uterus following too early usage of oxytocics. However, there

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AN INVESTIGATION INTO THE ETIOLOGY OF NAUSEA AND VOMITING OF PREGNANCY

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BECAUSE of the great number of patients coming to the obstetrical service of the University of Colorado Medical Center with emotional problems, a psychiatrist has been assigned permanently to the service. After being on the service but a short time, the author was impressed by three observations: (1) that nausea and vomiting to some degree is such a common complaint, (2) that individual observers have such different ideas as to the etiology of the condition, and (3) that practically any medication or treatment is helpful.

Because of the vastly different concepts of the etiology, the author became interested in pursuing the subject further to see what additional information could be obtained toward establishing the etiology on a firmer basis.

The condition varies from a slight feeling of nausea on arising in the morning and a distaste for food to a condition of severe dehydration, inanition, and apparent toxemia. It is referred to in the standard textbooks of obstetrics as nausea and vomiting of pregnancy only until it becomes vicious enough to endanger life; then it is called hyperemesis gravidarum.^{4,12,37}

A review of the English literature reveals that there are two schools of thought pertaining to the symptom. There are those who believe that the etiology is primarily organic, and there are those who subscribe to a psychogenic etiology with "feelings of rejection" being at the core of their theory.

The organic etiologies and their recommended treatments are multiple, and include disturbances of carbohydrate metabolism,^{8,11,38} vitamin deficiencies,³⁹ endocrine imbalances,^{34,35,36} protein intoxication,⁵ various sensitization phenomena, including sensitization of the mother to the semen of the spouse,^{6,21} reverse peristalsis of the gastrointestinal tract,¹ and unknown "toxins."^{4,12,28,37} Although individually many of the investigators mention changes in the blood chemistry to substantiate their respective theory, their results have usually not been confirmed by other observers.

Stander,³⁷ in summarizing these observations, states:

"In general, it may be stated that there is little change in the mild but considerable in the severe. The changes in the severe may be attributed to dehydration and tissue destruction."

As can be surmised because of the multiple etiologies there are a multitude of treatments and remedies. These include hormones,^{25,34,35,36} vitamins,^{10,30} ultraviolet irradiations,¹⁰ electrotherapy,²³ Dramamine®,⁶ antihistaminics,⁶ and various and sundry diets.^{7,12,37} The treatments are particularly interesting in that they vary so much and yet that all the authors report phenomenal cure rates.

It must be quite obvious that no definite organic etiology or cure for this symptom has been discovered since so many authors have produced so many different theories and treatments.

Since no organic cause has been found to be definitely etiological in itself, it seems probable that an emotional factor may be involved in some degree in the development of this symptom.

The literature^{4,12,37} mentions briefly that Kaltenback as early as 1891 believed that vomiting of pregnancy is usually a manifestation of a neurosis, somewhat allied to hysteria and readily amenable to suggestive treatment. Atlee also quotes Ferenzi in this connection:

"The occurrence of intractable vomiting in early pregnancy, which has always been given so many toxicological explanations, is still more comprehensible to the psychoanalyst. One is dealing with a defense or rejection tendency, directed against what is unconsciously felt as a foreign body, but displaced (in the psychological sense) and carried out in regards to the gastric contents. Only in the second half of pregnancy, when the movements of the child no longer permit even the hysterical woman to deny the genital location of the changes and sensations does the inclination to vomit cease."

William Menninger³⁰ in a more recent article substantiated this statement when he wrote:

"Vomiting of pregnancy is a more transparent symptom of rejection of pregnancy than many other neurotic

symptoms . . . in my experience 50 per cent of obstetricians queried regard the symptom as psychologically motivated, another 25 per cent regard psychological factors as being very important."

One of the earliest clinical reports discussing the psychiatric treatment of nausea and vomiting of pregnancy and citing cases appeared in 1911. Sir Allan Hurst,²⁰ writing in *Lancet*, stated categorically that vomiting of pregnancy is always hysterical and that all cases can be cured by psychotherapy.

More recently the psychiatric literature has had many clinical reports of successful treatment of nausea and vomiting of pregnancy with some form of psychotherapy.

Flanders Dunbar¹⁰ in an excellent review of the psychiatric literature in her book, *Emotions and Bodily Changes*, quotes many authors who believe the symptom is primarily psychogenic and that it can be treated successfully with some type of psychotherapy. These quoted authors explain that in some cases only suggestion is necessary while in others much longer and deeper forms of psychotherapy are indicated. This, of course, is in contradistinction to other writers who believe there are two types of nausea and vomiting—neurotic and organic—and cases are divided into these two groups on the basis of whether or not there is immediate response to suggestion.

In spite of the fact that many authors adhere strongly to their belief in an organic etiology for nausea and vomiting, the majority of them mention a neurotic component when they write of specific treatment. Beck,⁴ who emphatically believes in a basic toxic etiology, states:

"Suggestion should be liberally and seriously added to all measures."

It is obvious from the review of the literature presented that there are two schools of thought regarding nausea and vomiting of pregnancy. One considers the etiology as psychogenic, and the other considers the etiology as basically organic. As with all similar symptoms or illnesses, this sort of dichotomy is unrealistic and untrue. It does appear, however, from studying the literature that in most cases the most important factor in producing the end result is psychogenic and the most important factor in its alleviation is psychiatric. Stander,³⁷ who believes that the basic cause is toxic, says:

"In the great majority of cases the toxic factor acts merely as a predisposing cause in neurotic women and becomes negligible after the nervous equation has been controlled. Neurotic vomiting makes up the bulk that we are called upon to treat."

Acceptance of the fact that nausea and vomiting of pregnancy is partially or wholly psychogenic does not mean that a patient having this symptom necessarily has a neurosis. In the author's experience this is one of the main reasons that the psychogenicity of this symptom is not "really" accepted by the physicians practicing obstetrics. These physicians do give "lip-service" to the concept but later will add, "I do not really believe it because my wife (or some close friend or my mother) had it, and I am sure she is not a neurotic." William Menninger³⁰ states, regarding this point:

"The psychiatrist does not regard transient appearance of one or even several neurotic symptoms as indicating the presence of a neurosis, any more than rales are justification for the establishing of a diagnosis of pneumonia."

In other words, a single isolated symptom such as nausea and vomiting of pregnancy may indicate nothing but a transient unimportant disturbance or, on the other hand, a clinically severe pathologic condition.

Experimental Design and Results

The present study was conceived as an investigation to determine if patients with nausea and vomiting of pregnancy differ from those without the symptom regarding their feelings about five areas of their life: (1) pregnancy, (2) delivery, (3) marriage and family relationships, (4) children, and (5) spouse. From reading the literature, one gets the general impression that patients with nausea and vomiting are "neurotic" in their attitudes toward these areas while those patients without the symptom have "healthy" attitudes.

Patients for study were obtained from the obstetrical service of Colorado General Hospital and from employees and acquaintances of employees of the Colorado Medical Center. They were otherwise unselected. The only information given those who agreed to participate in the survey was that an investigation was being carried out on pregnant women, that it entailed seeing a psychiatrist for a short period of time, and that he would give them a psychological test.

NAUSEA AND VOMITING OF PREGNANCY—BERNSTEIN

TABLE I. COMPARISON OF GROUP I* WITH GROUP II** REGARDING TOTAL NUMBER OF RESPONSE INTERPRETATIONS IN THE TEST AREAS

		Pregnancy	Delivery	Family & Marriage	Children	Spouse
Group I	P	1		10	32	12
	R	12	7	12	10	20
	A	3		9	15	4
Group II	P	1	1	14	32	15
	R	13	9	19	11	25
	A	5		10	7	8

Key:

P—positive response

R—rejecting response

A—ambivalent response

*Those patients without nausea and vomiting of pregnancy.

**Those patients with nausea and vomiting of pregnancy.

When the patient arrived for her appointment, she was given a series of twelve pictures and told to tell a story in her own words concerning what is happening in each picture, what led up to the picture, and what is going to happen.* The pictures were chosen because the author felt they would bring out more of each subject's feelings regarding certain aspects of her life better than direct questioning in a psychiatric interview.** Sometime during the interview the subject was asked a few identifying questions including whether or not nausea and vomiting was present during the first trimester of pregnancy and whether or not the pregnancy was planned. On the basis of the presence or absence of nausea and vomiting to any degree the subjects were divided into two groups of ten each: Group I—those without nausea and vomiting; and Group II—those with nausea and vomiting.

The responses were interpreted and tabulated by the author in relation to the various areas as being positive, rejecting, or ambivalent. There were no essential differences in the responses of the subjects in the two groups taken either individually or collectively. The latter is well brought out in Tables I and II. For example, in the group with nausea and vomiting taken as a whole there were 170 responses, with 37 per cent being positive, 45 per cent rejecting, and 18 per cent ambivalent, while in the group without nausea and vomiting there were 147 responses, with 37 per cent being positive, 41 per cent rejecting, and 22 per cent ambivalent. Whether the pregnancy

*Based on the method of the "T.A.T." Morgan, C. D., and Murray, H. A.: A method for investigation phantasies: the thematic apperception test. Arch. Neurol. & Psychiat., 34:289-306, 1935.

**One of the patients was chosen by the author as a candidate for psychiatric treatment, and later it was noted that the feelings evidenced in the test were the ones that actually concerned her.

TABLE II. COMPARISON OF GROUP I* WITH GROUP II** IN RELATION TO TOTAL NUMBER OF RESPONSE INTERPRETATIONS

	Group I	Group II
P	55 (37%)	63 (37%)
R	61 (41%)	77 (45%)
A	31 (22%)	30 (18%)
Total	147 (100%)	170 (100%)

Key:

P—positive response

R—rejecting response

A—ambivalent response

*Those patients without nausea and vomiting of pregnancy.

**Those patients with nausea and vomiting of pregnancy.

was planned or not seems to have no bearing on the presence or absence of nausea and vomiting since the findings are about the same in both groups—six unplanned and four planned in Group I, as compared to seven unplanned and three planned in Group II.

Discussion

Since it is fairly well accepted that patients with nausea and vomiting of pregnancy are rejecting of certain aspects of their pregnancy, it remains to be explained why the data reveals that the group without the symptom are also rejecting and why the patients in this group do not vomit. As to why they do not vomit, two explanations are possible: firstly, the subjects in this group may have a higher vomiting threshold, which may well have both psychogenic and organic components; or secondly, these subjects may handle their feelings of rejection by other symptoms or through some type of acting out behavior. Concerning why the responses in both groups are so much alike, it is obvious that the common factor in both groups is a state of pregnancy.

Concerning "feelings" in "normal" pregnancy, Hirst and Strousse¹⁸ write as a result of studying 100 pregnant patients as follows:

"From this it may be deduced that most women are more anxious during the period of pregnancy and that the type of anxiety is chiefly conditioned by the economic and social group from which they were drawn. . . . The specialized types of anxiety were divided into four groups: (1) anxiety related to economic security, 75 per cent; (2) phobias, 16 per cent. . . ; (3) anxiety related to husband, 7 per cent. . . ; (4) anxiety relating to other members of the family, 10 per cent. . . . In the group of fifty cases adequately followed up after childbirth, even though the economic situation was unchanged, there was a definite lessening of anxiety in forty cases."

Apparently the patient's anxiety over the economic situation during pregnancy is just a manifestation of some underlying conflict.

W. Menninger³⁰ emphasizes the point that multiple changes occur in a pregnant woman and that the result of these changes may be evidenced by other symptoms besides nausea and vomiting.

"Even with complete willingness for the role there are so many changes in the physiological and social life of the woman that no prospective mother escapes from the emotional stresses that result from these changes. There are probably hormonal changes, which, even without a tumor of the abdomen, might theoretically account for some emotional changes from the normal. The pronounced readjustments required by this growing tumor—the disturbing of her activities and social relationships, the changes in her relationship with her husband, her wounded pride because of her 'deformity'—all are realistic causes for her emotional distress. The social status is an important determinant in the intensity of these maladjustments. For the social butterfly the 'figure' is all important; for the peasant laborer it is of no importance . . . in our culture even in the ideal situation of an intelligently desired pregnancy the woman may be expected to display some transient evidences of rejection or denial of the pregnancy. In every woman then we may expect positive and negative emotional attitudes to express themselves, sometimes fleeting, sometimes prolonged in duration—and these attitudes will be manifested in definite disturbances in her reactions and feelings. The specific reactions and disturbances may be understood only in terms of the life situation of that individual."

The author of this paper feels his experimental work validates Menninger's concept that all women are rejecting in some degree of their pregnancy, and that the effects of these feelings vary with the "life-history" and with the constitution of the pregnant woman concerned.†

The acceptance of this concept and the author's findings in accordance with it makes clear why some pregnant patients vomit and some do not, and why the labeling of the former as "neurotic" is not justifiable.

Summary

1. Nausea and vomiting of pregnancy occurs in one-half to two-thirds of pregnant women. It is called hyperemesis gravidarum when it becomes serious enough to endanger life.

2. The conclusion is reached from studying the literature that emotional factors, namely, feelings of rejection, are partly or wholly responsible for

†The author well realizes that his study suggests fields of further investigation, including the following: (1) studying and comparing larger series of patients in a like manner; (2) Rorschach studies of two groups of subjects similar to the ones investigated in this paper; (3) psychiatric studies of patients before conceiving as well as afterwards.

the development of nausea and vomiting of pregnancy and that the success in its treatment, reported by all authors, is due to suggestion.

3. Psychiatric study of ten patients with nausea and vomiting of pregnancy and ten patients without the symptom and comparing them individually and collectively reveals no essential difference in their attitudes toward important aspects of their life, namely, pregnancy, delivery, marriage and family, children, and spouse.

4. The explanation of the finding in this study that both groups react similarly to the areas tested is postulated as being due to the common factor in both groups—pregnancy.

5. The reason why one group manifested nausea and vomiting of pregnancy and the other did not, although both groups had about the same amount of rejecting feelings, may be explained as being due: (1) to different vomiting thresholds, or (2) to their handling their feelings of rejection through other channels.

6. The common practice of labeling pregnant women as neurotic just because they have nausea and vomiting with their pregnancy is not supported by this study.

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VOLUNTARY INSURANCE GAINS

According to a recent report of the Health Insurance Council, at least half of the nation's population at the end of 1950 was covered by one or another type of voluntary protection against the economic hazards of sickness and accident. The Council is composed of nine trade associations in the life insurance and casualty fields, and its report indicates that all forms of voluntary health protection showed tremendous gains in the past year to score new records.

Hospital expense protection, which covers the largest number of people, was extended to 76,961,000 persons at the close of 1950. This total was 17 per cent greater than the figure of 66,044,000 just a year before. Growing public appreciation of the advantages of voluntary health protection can be seen in the fact that the number of people protected against hospital costs has more than doubled since the end of World War II.

Great strides also were made by surgical expense and medical expense coverages in 1950. Protection against surgical expense was provided to 54,477,000 persons at the end of last year as compared with 41,143,000 a year

earlier, or an increase of 32 per cent. A year-to-year gain of 28 per cent was recorded by medical expense protection which covered 21,589,000 persons in 1950 and 16,862,000 in 1949. Both surgical and medical coverages also have shown larger postwar gains, with the 1950 number of persons in each case being more than quadruple the 1945 totals.

The over-all gains for the nation are reflected in the Empire State, according to the *United Medical Service Bulletin*. As of December 31, 1950, the number of subscribers was 1,948,904. This number had increased to 2,347,130 as of September 30, 1951, the latest available estimated figure.

Regarding amounts paid for medical care of U.S. subscribers for nine months of 1951, this figure stood at \$10,563,449. Perhaps this sum may seem tiny in these days of billion dollar budgets, astronomic debt, and skyrocketing expenses, but it is nevertheless a considerable number of dollars. What does it mean in relation to costs of coverage?—Editorial, *New York State Journal of Medicine*, Dec. 1, 1951.

DERMATOSES OF THE LOWER EXTREMITIES

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STASIS dermatitis and stasis ulcer are two of the most common skin conditions of the lower extremities. For that reason the bulk of this paper will deal with their recognition and treatment. Other cutaneous changes of the legs will be discussed briefly, chiefly in their relationship to the first two conditions mentioned.

Skin lesions of the lower extremities may be part of a generalized eruption or may be peculiar to the legs alone without a counterpart elsewhere on the body. Even those lesions which are part of a generalized condition may be modified by their location and differ considerably from lesions occurring on other surfaces. Dermatoses of the legs fall into groups similar to skin conditions occurring elsewhere on the body. An accurate diagnosis in all skin diseases is achieved by a careful consideration of the important primary and secondary lesions. There are certain primary and secondary lesions which are more applicable in the differentiation of lower leg dermatoses. These are multiform erythema, papules, vesicles, scale, hyperpigmentation and ulceration. Under these divisions will be found the dermatoses for consideration here.

Stasis in itself can have multiple causes, the chief one of which is interference with return flow from the legs because of incompetent veins. It is not my object to discuss the diagnosis of venous incompetence nor its treatment except insofar as it affects the skin. In the development of stasis dermatitis one may first see superficial red brown irregular macular pigmentation. The red color is due to extravasation of red blood cells within the skin. The color change is located principally over the medial lower leg especially about the medial malleolus, and extends proximally in a more diffuse fashion from that point. This discoloration ultimately is accompanied by a certain amount of scaling, atrophy, and in many cases verrucous change and edema. The dermatitis frequently becomes exudative as it becomes more severe and develops red exudative papules

around the periphery of the large plaque. Stasis dermatitis is more commonly found on one lower extremity but may be seen on both. The course of the disease is not necessarily a gradual one such as outlined here and the process may be persistent at any one of these points. At any one time one may see marked deep brown pigmentation of the leg resulting from chronic venous insufficiency. Extensive vesicular eczema or a dry scaling lichenified eczema of the leg with or without accompanying edema may also occur. The subjective symptoms may be few though there generally is some itching, at times quite severe.

Stasis eczema generally follows an irregular course with remissions and exacerbations. In many individuals a gradual fibrosis occurs in the leg with induration of the affected area. This induration adds to the already existent venous impairment and acts as a constrictive bandage on the leg. The progression is a vicious one with increasing edema which eventually fails to disappear completely when the leg is elevated. Then follows the woody edema and elephantiasic change with verrucous hypertrophy. This later stage is the late chronic one and is usually irreversible. The development of ulceration is the next step.

These ulcers generally develop within the areas of chronic eczema or cellulitis due to poor nutrition. Varicose ulcers appear more commonly on the medial side of the ankle just above the malleolus. However, they may be seen at other points of the lower leg including the lateral side. The ulceration is frequently accompanied by the superimposed infection and by infectious eczematoid dermatitis. The ulcer may vary in contour from round to one with a polycyclic border that has sloping or undermined edges. The base is usually dirty, containing necrotic material or purulent discharge. The ulcer may be single or multiple and vary in size from a superficial abrasion to one that may encircle the leg and take in a good portion of the lower leg. In most instances the free border is at the same level as the surrounding skin but may occasionally have a firm fibrotic rolled edge. This latter development appears in the more chronic ulcers and in those which show little tendency toward healing.

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DERMATOSES OF THE LOWER EXTREMITIES—FISHER

In the differential diagnosis of lower leg dermatoses the most important of the multiform erythema group are the nodose lesions. The lesions of erythema nodosum are prone to occur on the extensor surface of the lower leg. They consist of brilliant, red, tender, often painful nodules which seem to blend into the surrounding skin, which is frequently edematous. These lesions go through a characteristic cycle, flattening out and becoming more livid. They may ultimately go through a color change which resembles a resolving hematoma. These nodose lesions may appear on the thighs, forearms, gluteal region and more rarely elsewhere. They tend to disappear within two weeks and leave no scar. The condition has been given a position of considerable importance because of its relationship to certain of the systemic diseases, namely, tuberculosis, rheumatic fever, streptococcal infections and coccidioidomycosis. Localized thrombophlebitis with its erythema, edema and tenderness also resembles erythema nodosum.

Whenever one considers erythema nodosum, the lesions of erythema induratum are brought into play. Erythema induratum appears in its own more distinct location on the posterior lower legs. It begins as deep-seated nodules which become increasingly blue in color and progress to ulceration. These deep-seated ulcers are very slow to heal. Erythema induratum is considered a chronic benign form of tuberculosis that occurs more commonly in young individuals with a greater incidence in females.

In the scaling papular group one finds a number of pruritic and nonpruritic conditions. The chief among these are lichen planus, psoriasis, and lichen simplex chronicus. Lichen planus is well known for its peculiarly violaceous polygonal papules which may occur in groups sometimes forming large plaques though the papules generally remain discrete. This is an eruption that generally has other components elsewhere on the body with a predilection for flexor surfaces and mucous membranes. Psoriasis is characterized by papules over which one finds a lamellar scale that is removed with some ease. Psoriasis also may have small guttate lesions or appear in large well-circumscribed plaques. The lesions of psoriasis are found more frequently over bony prominences, and in the scalp. The lesion of lichen simplex chronicus is represented by a well-demarcated plaque, which may be red or red-brown in color and is characterized by lichenification. The heavy

scale may be a prominent feature. The principal symptoms are exaggeration of normal lines, thickening, and pruritus. When seen on the leg, the more common site is either above the lateral malleolus or in the popliteal area. This condition is most easily confused with stasis dermatitis.

The vesicular and bullous conditions of the leg are generally associated with similar conditions elsewhere on the body. The principal bullous lesions of the lower extremities are usually part of erythema multiforme, dermatitis herpetiformis, or pemphigus vulgaris. They are not readily confused with stasis dermatitis.

The last and possibly most important group consists of the conditions which are characterized either by ulceration or result in ulcerations of the leg. In passing only, one should mention such conditions as sickle cell anemia, scleroderma, and acrodermatitis chronica atrophicans. These conditions are in themselves rare and are not always accompanied by ulceration. The diagnosis of gumma always must be considered when a patient presents an ulcer of the lower extremity. Inasmuch as syphilis is a vanishing disease the presence of gumma is of lesser consideration. Certainly we should bear in mind that carcinomas can develop in any chronic ulcer. Ecthyma or traumatic ulcers do not have the accompanying signs of stasis ulcers.

The treatment of stasis dermatitis and stasis ulcer is dependent upon many factors. The most important one is correction of or support to the incompetent venous return. The vascular surgeon is better able to outline the criteria for the recognition of the various underlying conditions in varicose dermatitis and I shall not dwell on that. However, one must stress the need for correction of these factors. Correction may entail ligation of the greater and lesser saphenous veins with stripping and/or injection therapy. Many times ligation of the deep venous system may be necessary. Sympathectomy sometimes must be done in an effort to overcome the arterial and arteriolar spasm which often accompanies chronic venous impairment. From a dermatologic standpoint, however, one must point out that surgery alone will not always correct the cutaneous condition.

The dermatologic therapy is relatively simple. In the acute exudative process or infectious eczematoid dermatitis accompanying an ulcer, the best results are achieved with the use of continuous dermatologic wet compresses, rest and elevation of the extremity. At all times during the

care of the acute process we are of the firm opinion that any secondary infectious factors should be eliminated. These include the care of mycotic dermatitis and good hygiene. The good hygiene tends to militate against the development of small areas of thrombophlebitis. In the acute weeping eczema wet compresses with either boric acid solution, Burrow's solution, Darier's solution or silver nitrate 1:1,000 are of value in clearing the acute process as well as controlling the infectious factor. After the edema is gone it is possible for one to go to a bland lotion or paint. Antipruritic lotions and ointments are of value. As soon as the patient is up and about good support is of greatest importance. For good support one needs a firm elastic bandage applied properly and worn throughout the time the patient is up and about and removed only when the patient retires for the night. After the infectious element and the exudative process is under control there is no better supportive measure than the Unna boot. It acts as an excellent supportive agent and prevents excoriation on the part of the patient.

Such measures as antipruritic and stimulating ointments as well as superficial x-ray therapy is sometimes important in the handling of stasis dermatitis. The role of x-ray and ointments is more important in the chronic fixed process.

The care of ulcers is more difficult because their presence indicates severe vascular damage and greater neglect on the part of the patient. The ulcer must first be cleaned up with the use of wet compresses. After the infectious element is cleared, good support as well as compression dressing of the ulcer is necessary in order to reduce the venous stasis and promote epithelialization. The type of compression bandage familiar to most everyone and commonly used is that employing a rubber sponge underneath a firm elastic bandage. There is some merit in the application of adhesive strips across the ulcer. The rubber sponge is then applied over it. The rubber sponge

should extend beyond the sides of the ulcer and be held in place by a gauze bandage. Over this one should apply a firm elastic bandage. Some authorities stress the use of a heavy para rubber bandage extending from the toes to the knee with firm pressure over the sponge. It is not at all uncommon for one to apply an Unna boot to a leg that still has an open ulcer. I would say that support achieved with the boot is sometimes better than any other supportive measures utilized. The Unna boot is firm, elastic, gives clean support and stays in place without requiring any manipulation on the part of the patient. There are several commercially prepared bandages now available that have the gelatin impregnated within them and lend themselves to easier and cleaner application of the Unna boot. The bandage can be applied easily in the office and left in place for whatever length of time necessary. It can be removed and reapplied. After the ulcer is healed, good support must be maintained indefinitely.

More recently some degree of success has been achieved by the use of adenylic acid in an injectable form. My-b-den (Bischoff) is administered intramuscularly, giving 1 cc. every hour for five doses. This medication is carried out for about two days, at the end of which time the same drug is used as a suspension in gelatin and administered at daily intervals or every other day. There have been a number of instances in which the ulcer has been very resistant to treatment up until the time of the administration of this agent. Shortly thereafter the ulcer has proceeded to heal very rapidly. The total period of therapy varies up to three to four weeks.

The true solution to the problem lies in the adequate elimination of the underlying pathologic condition when and if possible. That elimination entails proper vascular surgery with correction of the stasis. These methods, meticulously carried out, will give the patients the best results one can offer for the present.

Every general hospital in this country, no matter how large or how small, can help eradicate tuberculosis in its own community. It can best do this by organizing and conducting its own tuberculosis control program. No other single agency has the opportunities for quickly finding and treating tuberculosis as has the general hospital. It has been estimated that every year about 16,000-

000 persons are treated in general hospitals of this country and that 40,000 of them have undiagnosed active pulmonary tuberculosis. Since these unsuspected disseminators of tubercle bacilli are not adequately isolated, they defy tuberculosis control measures until diagnosed. Tragically, they are within a few feet of the diagnostic instrument which is not used. —SYDNEY JACOBS, M.D., *Diseases of the Chest*, November, 1951.

KYPHOSCOLIOTIC HEART DISEASE

Report of Five Cases

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THIS report concerns five cases of pulmonary cardiac disease that are believed to be the result of deformity of the spine. An attempt will be made to show that the injurious effects exerted upon the heart by a marked kyphoscoliotic deformity may have their origin through involvement of either the greater or the lesser circulation.

Case 1.—A forty-seven-year-old woman was admitted to the hospital in 1948 because of increasingly severe dyspnea. Moderate exertional dyspnea had been present for a few years but had become subjectively handicapping only during the two months prior to hospitalization. Extreme deformities of the spine and rib cage had been present since the age of nine. Attempts at correction of these by various orthopedic procedures had failed. Other than the noting of muscular atrophy involving all four extremities and the very obvious bony deformities of the spine and thorax, little noteworthy was recorded on physical examination. The blood pressure was 116/80. An electrocardiogram contributed nothing towards a definitive diagnosis. Radiographic studies of the chest were difficult to interpret because of the marked angulation of the spine. Fluoroscopy, however, showed the lung fields to be clear. A few days following entry to the hospital, mental confusion and apathy, alternating with periods of excitability, developed. Following this, the patient lapsed into semi-coma and evidenced a Cheyne-Stokes type of respiration. The use of digitalis and oxygen caused no improvement, and she rather rapidly expired. Post-mortem examination revealed a pronounced dilatation and hypertrophy of the right ventricle. The lungs were moderately congested and quite emphysematous in appearance. The angulation of the spine was so marked that the bodies of the mid-dorsal vertebrae were in contact with the right lateral chest wall.

Case 2.—A forty-seven-year-old man was hospitalized in 1946 with complaints of recent onset of rather severe headache. Directly following this, he had developed cough, fever, dyspnea and marked fatigability. He had had a severe bout of what had been termed "bronchitis" ten years previously and at the age of eight was said to have had poliomyelitis. A marked

spinal deformity had developed following the childhood illness. The examiners noted a thin, asthenic individual who was orthopedic, cyanotic and subject to paroxysms of cough. The lungs were congested and the neck veins engorged. The blood pressure was within normal range. The patient expired thirteen hours after admission to hospital despite the use of oxygen and penicillin. Chest x-ray had shown an indeterminate type of infiltration in both lower lung fields. At autopsy, the aorta was found to follow a markedly angulated thoracic spine, but no reduction in the caliber of the aortic lumen was demonstrable. The right ventricle was hypertrophied and the circumference of the pulmonary ring was 1 centimeter greater than that of the aortic ring. A purulent-bronchitis, bronchiectasis and adhesive pleuritis were present. A fibrous pleuritis was found in both pleural cavities.

Case 3.—A twenty-four-year-old man had a kyphoscoliotic deformity dating back to an attack of poliomyelitis at the age of fifteen. An allergic asthma had been present since infancy and, following the development of the rib cage deformity, had become more troublesome. Physical examination fifteen months prior to death disclosed the presence of chronic dyspnea and a tinge of cyanosis. A diastolic murmur was present at the cardiac base which was transmitted down the left sternal border. This murmur could be altered in intensity by changing the contour of the thoracic cage. The blood pressure was not abnormal. Roentgenologic studies showed enlargement of the pulmonary conus area and there was fluoroscopic evidence of emphysema. The P waves in limb lead II of the electrocardiogram were suggestively peaked and the T in precordial lead IV was inverted. Dyspnea became increasingly more pronounced, and the terminal episode was essentially that of pulmonary insufficiency with failure of the right heart. At necropsy the significant findings included marked dilatation and hypertrophy of the right ventricle, dilatation of the right auricle, and the presence of a bicuspid pulmonary valve. The bicuspid valve did not appear to be functionally insufficient. The right lung was markedly compressed and the left lung emphysematous.

The last two cases illustrate a different set of circumstances that may conceivably exist in kyphoscoliotics.

Case 4.—A thirty-two-year-old switchboard operator, when first examined in 1933, complained of cough, dyspnea and pain in the chest of a pleuritic nature. She was a small thin woman with a marked kyphoscoliotic deformity which dated to a childhood poliomyelitis. During a seven-year period of observation, blood pres-

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sure readings varying between 150/100 to 250/150 were recorded and one episode somewhat suggestive of hypertensive encephalopathy had occurred. Chest x-rays taken in the routine postero-anterior view were rather uninformative due to the extreme kyphosis and angulation of the spine. Death was apparently precipitated by a respiratory infection which had been accompanied by increasingly severe dyspnea. At autopsy all of the cardiac chambers were found to be dilated and the left ventricle hypertrophied. The lungs appeared to be compressed and the lower lobes were atelectatic. The aorta was found to follow the spine, which was markedly angulated. At the most acute angle, there was a definite and marked reduction in the caliber of the aortic lumen. It was postulated at the time of autopsy that this mechanical effect might have been partly or wholly responsible for the hypertension. Unfortunately, none of the confirmatory clinical evidences of this "coarctation-like" effect had been recorded during life. Renal insufficiency, at least to any marked degree, had apparently not developed. Microscopically, the vascular changes in the kidneys were not too prominent and fairly well excluded any primary renal origin for the hypertension. These microscopic findings, however, could be considered quite compatible with those observed in essential hypertension.

Case 5.—A twenty-four-year-old chemist, seeking medical advice for an incidental complaint, afforded the opportunity of recording a somewhat similar variant of the kyphoscoliotic syndrome. He had developed spine and rib cage deformities following a tuberculous infection of the spine and hip during infancy. At the age of six, his parents had been told that he had a "heart murmur." At the age of eighteen, hypertension was found on routine physical examination. This finding has since been moderate in character but definitely sustained. No symptoms referable to the cardiovascular or respiratory systems have developed. On examination there were soft systolic murmurs at the apex and base and also a blowing diastolic basal murmur. This diastolic murmur has since been noted to be evanescent in character. The femoral pulses were barely discernible. The blood pressure in the arms varied from 150/100 to 170/110. In the legs a pressure of 90/60 was found on the right and no reading was obtainable on the left. There was x-ray evidence of an extreme degree of rib-notching and of moderate left ventricular enlargement. No significant electrocardiographic abnormalities were present. Exploratory thoracotomy was carried out in May, 1949, and it was found that the aorta had a normal caliber to the point where the descending portion joined the spine. At this level, which was below that of the ligamentum arteriosum, the size of the aorta was rather suddenly reduced by approximately one-half. Below this point the aorta remained narrowed to at least the level of the diaphragm. The left subclavian artery was dilated to approximately the same size as the aortic arch. The surgeon noted the presence of enormously dilated vessels about the tip of the scapula as he made his entry into the chest. No definitive surgical procedure was feasible, and to date the status of this patient remains unaltered.

In evaluating thoracic deformity as an etiologic diagnosis of heart disease, the deformity should be great enough to cause either direct mechanical interference with the heart action itself or interference with blood flow in the aorta or the pulmonary circuit.⁴ The first three cases cited are believed to be examples of cor pulmonale due to interference with the dynamics of the lesser circulation. In the literature on kyphoscoliotic heart disease, the protocols presented appear to be concerned nearly entirely with this type of situation.^{1,3} The rib cage deformity in itself must encroach upon functioning lung volume to some extent. However, it is a good assumption that this deformity brings into play a secondary chain of events that further hamper pulmonary function. A fixed distorted rib cage and restricted diaphragmatic movement results in a cough of poor expulsive force. This sets the stage for the development of atelectatic pneumonitis, bronchitis, bronchiectasis, bronchopneumonia, adhesive pleuritis and pulmonary fibrosis. These are common developments in kyphoscoliotics, and they all serve to further reduce the vital capacity, to increase the ratio of residual air to vital capacity and to promote the formation of emphysema. Thus the primary difficulty with these patients is that of pulmonary insufficiency. The failure of the right heart, if it develops, is only a secondary event.

As in the presence of severe idiopathic pulmonary emphysema, it should be remembered that the use of respiratory depressant drugs or of continuous oxygen therapy may be very hazardous by interfering with carbon dioxide elimination. Any respiratory depressant may increase the already existing difficulty. The continuous use of oxygen may take away the only stimulus the patient has left to respiration, namely, the oxygen want. Both of these therapeutic agents may then produce a severe respiratory acidosis with rise in cerebrospinal fluid pressure—an event that may well have a fatal outcome.

It should also be pointed out that many of the kyphoscoliotic deformities develop during childhood. It is stated that the lungs of some adults who developed the spinal deformity during childhood have the appearance of infantile lung tissue.³ The life span of childhood kyphoscoliotics is relatively much shorter than that of those who develop the deformity during adult life. There is at least some evidence indicating that lung tissue during the growth period can actually regenerate itself if

called upon to do so, whereas in the adult the lung has only to resort to the formation of emphysema when its ventilatory function is hampered.² This is only one of the many reasons for attempting to prevent and correct the spine deformity as early in life as possible.

The outstanding feature of the last two cases is the presence of hypertension. In the autopsied case (Case 4), the clinical evidence that stenosis of the aorta was responsible for the blood pressure elevation is very unfortunately lacking, but the post-mortem studies suggest that such might have been the case. The clinical findings and the observations made at thoracotomy in the last case offer convincing evidence that a coarctation-like effect was in operation. The assumption is made that the hypoplastic aorta developed during the growth period as an accompaniment of the angular deformity of the spine. This, of course, is pure speculation and does not at all exclude the possibility that the malformation of the aorta was congenital in origin. There are very few cases of this kind on record, and those that have been presented are far from convincing in attempting to demonstrate the connection between the kyphoscoliosis and hypertension.

The life span of those kyphoscoliotics who develop pulmono-cardiac difficulties is shortened. This clinical observation was first made by Hip-

pocrates. In his forty-sixth aphorism he states that "such persons as become hump-backed from asthma or cough before puberty, die." Many kyphoscoliotics may live to a ripe old age. This observation was also made by Hippocrates, i.e.: "and in those cases where the gibbosity is above the diaphragm, they become affected with difficulty in breathing. And yet many of them have borne the affection well and have enjoyed good health until old age, more especially those persons whose body is inclined to be plump and fat; a few of them lived beyond sixty years of age, but the most of them are more short-lived."

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POSTPARTUM HEMORRHAGE

(Continued from Page 33)

seems little argument that the blood loss is minimized with early usage of pitocin.

If the placenta does not separate readily and bleeding appears to be excessive, one should attempt to express it. The uterus should not be handled too vigorously, however, as fingers pressing into the wall may cause serious damage, as well as causing irregular separation of the placenta at times. Pressing downward on the fundus has also been known to cause inversion when done too forcibly. Gentle kneading of the fundus is preferred, and downward pressure of the fundus to the extent of delivering the presenting edge of the placenta to the vaginal outlet is perfectly acceptable.

Another difference of opinion exists over management of the third stage when the placenta

fails to deliver within a few minutes. Many contend that as long as bleeding is absent, the placenta can be left indefinitely. The greatest extreme to this is routine manual removal. It seems best to adopt a middle-of-the-road course, which would appear to be manual removal at the end of an hour (or after estimated blood loss of more than 400 cc.), all else failing. With antibiotics available, the procedure can no longer be condemned, and can be carried out with safety.

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THE ECONOMIC VALUE OF HIGH QUALITY MILK

MYRON W. CLARK

Saint Paul, Minnesota

IT takes high quality milk to produce good dairy products, but sometimes we are slow to recognize the economic value of that high quality milk. When we speak of economic value, we think of dollars and cents. Let's take a look at the record. In 1950, we produced in Minnesota 8,253 million pounds of milk. Forty-four per cent of this was sold as cream. The records show that 105,721,698 pounds of butterfat was purchased in Minnesota as sweet cream; 33,948,673 pounds of butterfat was purchased in Minnesota as Grade 1 cream; 3,861,879 pounds of butterfat was purchased as Grade 2 cream. It is required in Minnesota that at least three cents differential be paid between grades of cream. On the basis of a three-cent differential, had the nearly four million pounds of butterfat in Grade 2 cream and the nearly thirty-four million pounds of butterfat in Grade 1 cream been of high enough quality so it could have been purchased as sweet cream, the farmers who produced it could have pocketed over \$1,260,000 in additional income.

As a further example, about 46 per cent of the 1950 production of milk in Minnesota was sold as whole milk. Again a look at the record shows 21,686,275 pounds of butterfat was purchased from producers as market milk, what we generally think of as bottling milk; 102,336,763 pounds of butterfat was purchased in Grade 1 milk; 10,878,428 pounds of butterfat was purchased in Grade 2 milk. Had the producers of this milk been sufficiently informed and equipped and taken care enough to have kept this Grade 2 milk in the Grade 1 class, they could have enriched their coffers to the tune of more than thirty-one million dollars, and by some stretch of the imagination if we could assume that a sizable portion of this Grade 1 and Grade 2 milk could have been marketed as Grade A market milk, the economic advantage to the producer would have been astounding. At present prices, even a small producer with 600 pounds of milk per day can receive an additional \$100 a month if his product is Grade A. I think these figures indicate that

high quality milk has real economic value to the producer.

We have done a creditable job of increasing production of dairy products. We have seen the production possible from one animal increase again and again until one cow has produced more than 41,000 pounds of milk a year. This very year we are producing more milk than at any other time in our history from fewer cows than we have kept for milk in any of the last twenty-five years; however, with the rapid strides and advancement that we have made in production, we have not kept pace in the quality improvement we have maintained in our dairy products, and it behooves each of us to make a greater effort along this line.

It is in the economy to the processor that the real value of high quality dairy products shows up. By way of comparison, the State of New York and the State of Minnesota have about the same number of cows kept for milk, yet the farmers of New York received last year \$142,500,000 over that received by Minnesota farmers for the products of those cows. The average price paid per 100 pounds of milk in Minnesota was \$2.57, while in New York the average price was \$4.04. Certainly there are many other things besides quality which affected this great difference in price, but in the high competitive world in which we live, we must maintain high quality in order to insure a market for our products. For the great quantities of dairy products which we produce in Minnesota, we must find a market for more than 80 per cent of these products outside of the state, and these out-state markets which have become highly competitive are based on quality.

The National Conference on Interstate Milk Shipments, which sets up standards and agreements by which milk and milk products are shipped from one state to another, leaves no doubt in our mind that if we as a state are going to cultivate the markets we must have, it will come only through maintaining high quality.

High quality milk has economic value to the consumer. A spokesman for U. S. Public Health

Read at the Public Health Conference held at Minneapolis, Minnesota, September 28, 1951.

Myron W. Clark is commissioner, Department of Agriculture, Dairy and Food, State of Minnesota.

(Continued on Page 72)

Presentation of Distinguished Achievement Awards

To Medical and Nursing Graduates of the University of Minnesota

DURING 1951, the centennial year of the University of Minnesota, the several schools and colleges of the University were authorized by the Regents to nominate certain of their graduates, not currently associated with the University, for Distinguished Achievement Awards. The presentation of these awards was made to graduates of

the Medical School and affiliated units of the University at a special faculty dinner held October 8, 1951 in the ballroom of Coffman Memorial Union. This ceremony, which was attended by almost 500 persons, was a delightful occasion. Dr. George Aagaard served as master of ceremonies and introduced the several participants in the program.

THE UNIVERSITY'S COLLEGE OF MEDICAL SCIENCES

HAROLD S. DIEHL, M.D., Dean

Never before have we had such an occasion as this at the University of Minnesota. We have had other medical faculty dinners, and on rare occasions the medical faculty has expressed itself concerning its dean. But never before has our Medical School or our College of Medical Sciences been privileged to recognize the distinguished achievements of certain of our graduates. That, Ladies and Gentlemen, is the high point of our evening. But before we get to that we have some other things to attend to that I hope will be of interest.

Possibly to our guests a word of explanation concerning the College of Medical Sciences would be helpful. The Medical School has been an educational and administrative unit in the University for more than half a century. In recent years, however, the activities of this unit have expanded so greatly that the designation Medical School did not seem an adequately descriptive title. Consequently, President Morrill and I recommended to the Regents that this unit be rechristened the College of Medical Sciences. This College is now an administrative unit that includes the Medical School, the University Hospitals, the School of Nursing, the School of Public Health, the Courses in Medical and X-ray Technology, the Course in Physical Therapy, the Course in Occupational Therapy and the Department of Continuation Medical Education.

The meeting this evening is a dinner of the faculty of this College of Medical Sciences. And the first item on our program is my report on some of the major developments, activities, achievements and problems of this unit.

The Medical School

First, for a brief report on the Medical School. For a good medical school or a good school of any type for that matter, one needs a strong and active faculty, an able student body, a sound educational program and adequate facilities and sup-

port. I feel that we have such a faculty in each of the units of this College. Tangible evidence of this is the national and international recognition constantly accorded members of our staff. I wish that I had time to tell you of the important lectureships, consultantships, offices in professional and scientific societies, and prizes and awards received by members of our faculty. Unfortunately, time is too short to permit of this.

In the past year we have lost or are about to lose some faculty members whose places it will be hard to fill. Among these are Dr. Clarence Dennis, who left us to become professor and head of the department of surgery of the State University of New York College of Medicine in New York City; Dr. Arthur Kirschbaum, who resigned to become professor and head of the department of anatomy at the University of Illinois; Dr. William Cromartie, who is leaving us to become director of laboratories in the new University Hospital at the University of North Carolina, and Dr. George Aagaard, who on January 1 will take over the deanship of the Southwestern Medical School of the University of Texas in Dallas, Texas.

We are honored that members of our staff are selected for positions of such importance at other institutions, and their leaving creates opportunities for the advancement and further development of other young men here. On the other hand, the departures of such intimate friends and valued members of our group leave voids and heartaches that are slow in healing.

As to our students: we have exactly five hundred undergraduate medical students this year. This is the first time since World War II that all classes have been completely filled. Applications for admission continue to be several times the number of places available. This does not mean, however, that we are rejecting large numbers of well-qualified applicants. On the contrary, even this year the last students selected by

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the Admissions Committee were accepted without great enthusiasm. They, as well as a good many others, have met our minimum entrance requirements, but they do not give great promise as medical students.

Our freshman class numbers 126, which is about twenty-six more than we should accept with our present staff, facilities, and budget. However, the current need for physicians and the large number of veterans of World War II still applying for admission caused us to stretch the number of admissions beyond the optimum number. In fact, the Administrative Committee of the Medical School, feeling that the need for physicians in connection with the national defense effort is of very real urgency and importance, indicated its willingness, if the necessary funds are provided, to adopt for a limited period of time an accelerated curriculum such as we conducted during World War II. Under this program an extra class can be graduated each three years. However, neither the state nor the federal government has provided the funds to cover the additional costs of such a program, so nothing further has been done about it.

A major change in the curriculum of our Medical School was made several years ago when pre-medical requirements were modified to provide a broader and more liberal general education and the medical course proper was extended to include in the school year for freshmen, sophomore and junior students, the first six weeks of the usual summer vacation. At the same time, the number of hours of formal instruction in several departments were reduced. This change was made to permit the incorporation of certain new materials in the medical curriculum and to give the students more time for study and independent reading and work.

A further though relatively minor change in the curriculum was made effective this year. This provides for the elimination of all lectures and formal classes for junior students except during the first hour in the morning, that is 8 to 9 o'clock. Under this program the students will devote the entire day, except for this hour, to clerkship work and to the conferences, reading and studying pertinent thereto. Our alumni will recognize this as quite a change from the days that we spent taking notes in lecture halls from morning to night throughout the junior year. The current plan places upon the student a much greater responsibility for his own education and requires a much larger teaching staff for intimate supervision and clinical instruction, but we are convinced that the results are far better than those obtained under the old system.

Graduate Medical Education

In addition to undergraduate medical teaching our medical school carries a major program of graduate medical education. This includes ad-

vanced training both in the basic medical sciences and the various clinical specialties. During the past year more than 500 graduate students devoted full time to these various programs. This number together with the approximately 500 fellows in the Mayo Foundation of our Graduate School means that the University of Minnesota has the largest graduate training program in medicine of any university in this country—that means of any university in the world.

The clinical training of these graduate students is being carried on primarily at the University Hospitals, the Minneapolis General Hospital, the Minneapolis Veterans' Hospital and Ancker Hospital of Saint Paul, all excellent teaching hospitals. In addition affiliations for graduate training have been operating at Miller Hospital, Saint Joseph's Hospital, the Children's Hospital and Gillette Hospital in Saint Paul and with Northwestern Hospital, Saint Barnabas Hospital, the Shrine Hospital, the Kenny Institute and Glen Lake Sanatorium in Minneapolis.

This advanced training of carefully selected graduate students, some of whom go on to careers in medical teaching and research, is an important contribution to the forward progress of medicine in our state and nation.

Continuation Medical Education

Another activity of the Medical School which has come to gain a position of major importance is our program of Continuation Medical Education. This program was effectively pioneered by Dr. William O'Brien and has been splendidly developed during the past four years by Dr. George Aagaard. During the past year 24 courses for physicians, mostly of three days' duration, were offered at the Center for Continuation Study on the campus, and thirteen courses were arranged in various communities throughout the State. A total of 1909 physicians attended these courses. In addition, 1,621 individuals attended twenty-one similar courses offered by other divisions of the College of Medical Sciences. Altogether, these programs make an important contribution to better medical care and other health services in this area. Our big problem for the future is to find a successor who can carry forward the work of this department which Dr. O'Brien and Dr. Aagaard have so effectively developed.

The School of Nursing

The School of Nursing, like the Medical School, offers an advanced as well as basic instructional program. In fact, a major responsibility of a University School of Nursing is to prepare selected young women for positions of leadership in Nursing Education and Nursing Service.

At the University of Minnesota the basic nursing course was revised several years ago to make

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it possible for young women to obtain a Bachelor of Science degree in nursing in four calendar years instead of five years as previously. For the first two years of this program enrollment in the first clinical year averaged less than twenty students per class. Last fall, enrollment in the first clinical year increased to forty-seven, and this year we have seventy-two students in this class. We are encouraged by this increase because we are convinced that this program is sound, and certainly there is urgent need for more well qualified nurses. Personally, I look forward to the time when we will have more applicants than we can accept and will be selecting nursing students much as we now select medical students.

Advanced or postgraduate programs are offered in the fields of nursing education and the various clinical specialties of nursing, such as surgical nursing, operating-room nursing, psychiatric nursing, obstetrical nursing, etc. Last year approximately 150 nurses were enrolled in these various postgraduate programs. With the increase in the numbers of auxiliary nursing personnel in hospitals, the training of competent nursing supervisors and administrators becomes of increasing importance.

In the area of practical nursing, two programs have been successfully tried—one, a four-quarter program in practical nursing, and the other a six-quarter program in home management and practical nursing. The progress which these programs are making is encouraging.

In connection with nursing, I must take time to mention the heroic rescue work that Dr. Cowling did this past summer for the graduate nursing program. This program has been supported for the past five years by grants from the Kellogg Foundation. Unfortunately, the end of this support came last June when the University had no funds for new positions. Then our good friend, Dr. Cowling, went to several individuals and groups in Minneapolis, St. Paul and Duluth and obtained in excess of \$20,000 to support this program during the current year. We are deeply appreciative of this support because it would have been nothing short of a calamity to discontinue this program at a time of such urgency.

One other comment about the School of Nursing: that is, that the Kellogg Foundation has just given the University a 5-year grant totaling approximately \$100,000 to develop a program in Nursing Service Administration. This grant is further evidence of the high regard in which our School of Nursing is held by people whose business it is to know the fields of Nursing Education and Nursing Service.

School of Public Health

Our School of Public Health is truly an international settlement. Of its 250 full-time students, little less than half are from the State of Minnesota. The others are drawn from thirty-

four other states and nineteen foreign countries. This is very clear evidence that this school has an international as well as a national reputation.

The School of Public Health offers programs of instruction and training for medical officers of health, for public health engineers, for public health nurses, for public health educators and for hospital administrators.

This youngest of our schools in the College of Medical Sciences is doing a job of which we are truly proud.

Medical Technology

Our four-year Course in Medical Technology continues to give the best of training to the fifty or sixty able young women who each year select this important field of medical service. All of the graduates of this course have multiple and attractive opportunities for employment before graduation. In fact, the demand for our graduates so far exceeds the supply that we wish we might have 25 to 30 more students per class.

Physical Therapy and Occupational Therapy

Our courses for physical therapists and for occupational therapists were inaugurated during World War II to help meet a growing national need. Both courses are four years in length and lead to a Bachelor of Science degree. Current facilities for training necessitate a limit of approximately twenty-four students per class in physical therapy and twenty-four students per class in occupational therapy. Applicants for both programs exceed the places available. However, in spite of most inadequate facilities our faculties in both of these courses are conducting splendid programs. When we get the new Mayo Memorial, the situation for these units will be materially changed, for we will devote two floors of the tower portion of this building to a physical medicine and rehabilitation center.

Medical Research

Next a few words as to research. Today, I think, everyone accepts the advancement of knowledge as a major responsibility of a true university. In the area of research the members of the faculties of our College of Medical Sciences are exceedingly active and are achieving results that are bringing distinction to our university and to our state. In spite of this, there is much misunderstanding concerning the relation of medical teaching and medical service to research.

I well remember when I was a freshman or medical student that we were amused by the information that one of our instructors had done the research for his Ph.D. degree on "The Occurrence of Conjugated Benzoic Acids in the Urine of Sand Sharks." Whether that research had any importance I still do not know, but I do know that an investigator can develop interest in and

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obtain scientific training and insight from studies that seem as bizarre as the research interests of our former instructor.

The other day a freshman medical student said to me that he had heard from some doctor that the

College of Medical Science received more than \$1,250,000 from sources other than the university budget for the support of medical research. The fields of research supported by these funds are many and diverse; although our major pro-

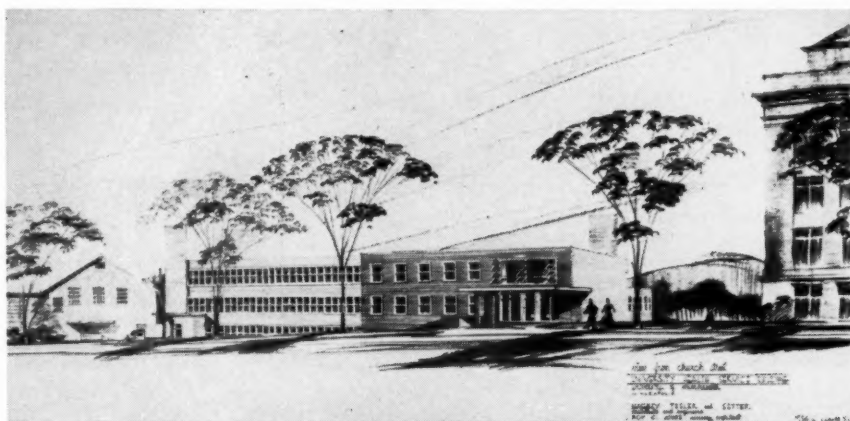


Fig. 1. Architect's drawing of the newly completed University Health Service Building.

medical school of the University of Minnesota is a research school and that if one wants a good preparation for medical practice, he should go elsewhere. What a distressing lack of understanding such statements indicate!

Research is the spirit of inquiry put to work; and how bankrupt is a medical education that does not imbue the student with this spirit and give him a sound scientific basis upon which to keep building professionally throughout life. To learn the facts and the techniques of present-day medical diagnosis and treatment is most inadequate.

I like Charles Kettering's explanation of research. "Research," he said, "is a high-hat word that scares a lot of people. It needn't. It's rather simple. Essentially, it is nothing but a state of mind—a friendly, welcoming attitude toward change. Going out to look for change instead of waiting for it to come. Research, for practical men, is an effort to do things better and not be caught asleep at the switch. The research state of mind can apply to anything: personal affairs or any kind of business, big or little. It is the problem-solving mind as contrasted to the let-well-enough-alone mind. It is a composer-mind instead of the fiddler-mind. It is the 'tomorrow'-mind instead of the 'yesterday'-mind."

So I am proud of the research activities and achievements of the members of our faculty. I wish that time permitted me to enumerate the research programs and projects under way. They are concerned with practically every aspect of the basic sciences and of clinical medicine.

Some idea of the extent of our research activities is conveyed by the fact that last year the

grams of research are in the fields of cancer and cardiovascular diseases.

The sources of these funds were the Minnesota State Legislature, the Minnesota Division of the American Cancer Society, the Minnesota Society for Crippled Children and Disabled Adults, the National Institutes of Health of the U. S. Public Health Service, the U. S. Army, the U. S. Navy, the Atomic Energy Commission, the Veterans Administration, the National Research Council, the National Foundation for Infantile Paralysis, the American Cancer Society, the Allergy Foundation, the Nutrition Foundation, the Research Foundation, the Harriet Beecher Fund, other private foundations, the National Academy of Sciences, the Life Insurance Research Fund, pharmaceutical and other business corporations, finally and of very real importance, contributions by individuals.

In summary, \$75,000 of the total came from the Minnesota Legislature, \$862,000 from the federal government, and \$384,000 from private sources. I might add that these totals do not include several endowed or privately supported research professorships, such as the George Chase Christian Professorship of Cancer-Biology, the American Legion Research Professorship in Rheumatic Fever and Heart Diseases in Children, the William A. O'Brien Professorship of the Minnesota branch of the American Cancer Society, the Pardee Cancer Research Professorship, the Mayo Professorship of Public Health. Nor do they include the capital research funds such as the Silas B. McClure bequest for half a million dollars for medical research recently received,

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nor the George C. Dittman bequest of approximately \$400,000 for teaching and research in ophthalmology and otolaryngology. These totals also do not include the special fellowships and scholarships for selected graduate students supported

I am pleased to report that finally we are getting some tangible results. During the past year two new buildings were completed and occupied. These are the Student Health Service and the Variety Club Heart Hospital.

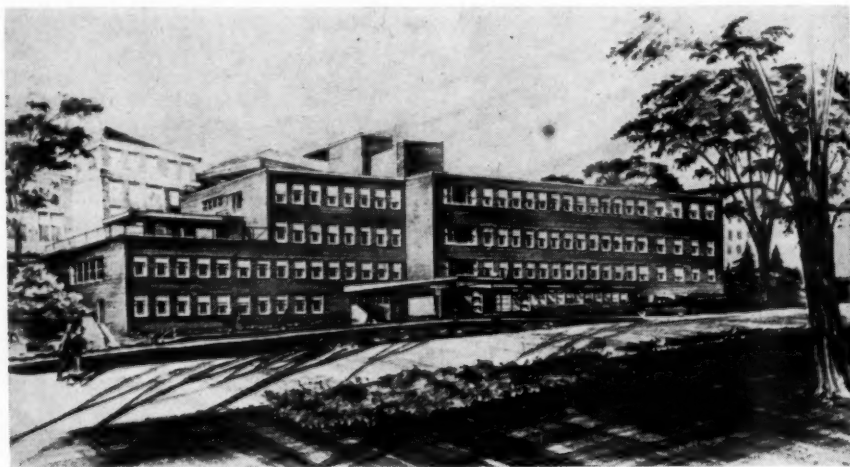


Fig. 2. Architect's drawing of the newly completed Variety Club Heart Hospital.

from sources other than the University of Minnesota, which during the past year had a value in excess of a quarter of a million dollars.

I mention the amount of these research grants primarily to give some indication of the extent of the medical research in progress at the University of Minnesota, but the number and the amount of these grants has another implication, that is, since most of these grants were awarded by nationally chosen experts in their respective fields, the number and total of them is objective evidence of the high esteem in which the research workers and the research work at this institution are held. Meeting with these national groups from time to time I am proud and honored to represent the University of Minnesota.

Teaching and Research Facilities

Now a few words concerning our facilities. These facilities are in part on the campus and in part in affiliated hospitals, such as the Minneapolis General Hospital, the Minneapolis Veterans' Hospital, and Ancker Hospital of St. Paul. These are excellent institutions and we are exceedingly fortunate that we have them available and receive from them the splendid cooperation that exists at the present time.

On the campus we have long had a good Medical School plant and a fine University Hospital, but in recent years both of them have become very inadequate for the activities which go on in them. For a considerable number of years we have been striving to improve these facilities and

The Student Health Service

The Student Health Service is not administratively responsible to the College of Medical Sciences, but the Health Service and the Medical School function so intimately together that we feel that they belong to our family. The new Health Service Building (Fig. 1) is a beautiful and modern health center and out-patient clinic. Students who are bed patients will continue to be cared for on the fourth and fifth floors of the old Health Service Building. The first two floors of this same building have been available to the University Hospital and are being utilized for the extension of our out-patient clinics. The top floor of the old Health Service has been remodeled for offices, research laboratories, and labor and delivery rooms for the Department of Obstetrics.

The Variety Club Heart Hospital

This hospital, which only recently was placed in complete operation, is a splendid unit for teaching, research and for the care of patients with cardio-vascular diseases (Fig. 2). The west half of the first floor of this building is devoted to an out-patient clinic and the east half to the administrative offices, the x-ray department and research laboratories concerned with the study of congenital heart disease. The second floor contains forty beds for adult patients. The third floor is the children's unit of forty beds, while the fourth floor is devoted entirely to research laboratories. Approximately one-half of this floor is

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utilized for the study of infectious types of heart disease such as rheumatic fever, while the other half is utilized for the study of degenerative types of cardiovascular disease, such as coronary occlusion, arteriosclerosis, and hypertension.

Legislature adjourned without making any appropriation for this project. That failure necessitated a major revision and curtailment of our plans.

Bids on these new plans and specifications were



Fig. 3. Architect's drawing of the Mayo Memorial Medical Center of fourteen stories now under construction.

If there are any of you who have not seen this building, I would urge you to take time to go through it.

The Mayo Memorial

The building known as the Mayo Memorial was first proposed more than ten years ago. Its purpose was to provide improved and expanded facilities for the Medical School, the University Hospital, and other units of the College of Medical Sciences. Eighteen months ago we had twelve and a quarter million dollars and plans partially completed for a twenty-two story building for this development. Contracts for the excavation and footings and for underground services were awarded before the outbreak of hostilities in Korea and this work was completed last January. Unfortunately, the 25 per cent increase in building costs during the last six months of 1950 caused the bids for the construction of the building, received last February, to exceed by approximately three and a half million dollars the money available. Modifications in specifications, such as the substitution of a large amount of baked enamel for stainless steel, the substitution of wood windows for aluminum windows, the elimination of a great deal of tiling, et cetera, reduced the deficit to two-and-a-half-million dollars. The committee of Founders, of which Dr. Donald J. Cowling is chairman, requested a deficiency appropriation in this amount from the Legislature. And until the last evening of the legislative session, we were hopeful that this appropriation would be granted. However, as you know, the

received about a month ago and fortunately are within available funds. The major change involved in our plans was in the reduction of the tower portion of the building from twenty-two to fourteen stories. In addition, eliminations and substitutions of less expensive materials were made wherever possible. Contracts on this building have been awarded by the Regents, and I am glad to say that work is again under way with a scheduled completion date of January, 1954.

It has been a depressing sight that I have had for the last nine months, looking out of my window into the chasm of the excavation with nothing going on. During this period, as you know, there have been various suggestions for the use of this hole, such as filling it with water, stocking it with fish and calling it "Diehl's Lake."

The perspective of the curtailed fourteen-story building is shown in Figure 3. Fortunately, the bids permit us to include the auditorium and classroom unit which is urgently needed. The auditorium will seat approximately 600 persons, and beneath the auditorium will be two classrooms which will contain something over 150 seats each. We were able also to include a two-level underground garage which will provide parking facilities for 325 cars. The finishing of the fourteenth floor of the tower which will provide offices and research laboratories for the Department of Pediatrics is not included in the construction contract. We are very hopeful, however, that we shall be able to finish this out of the contingency fund.

The eight floors eliminated from the tower were

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the two floors for pathology, two floors for cancer biology, one floor for biophysical research, one floor for histo-cyto-chemical research, a half floor for the School of Public Health and a half floor for offices and conference rooms for the

library. Actually, before the plans for the Mayo Memorial crystalized, the faculty voted that provision for the medical-biological library on the medical campus was a top priority need for the Medical School. As it appeared then that there

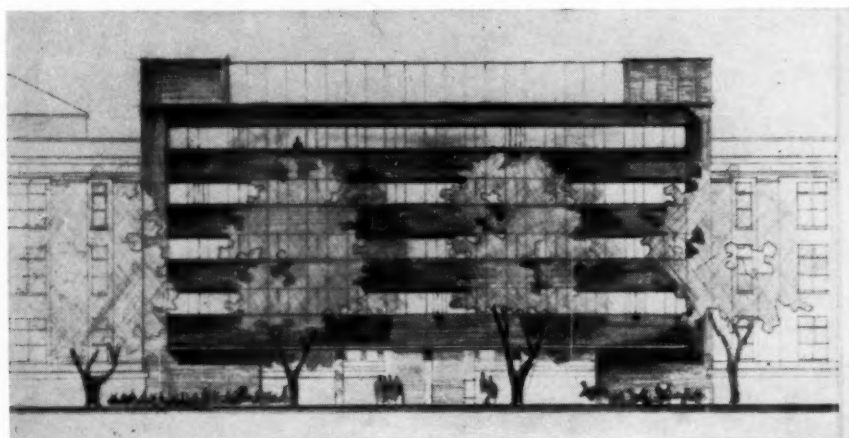


Fig. 4. Proposed building for Cancer and Heart Research to join Millard Hall and the Anatomy Building.

Medical School and the department for Continuation Medical Education and a floor for the Medical-Biological Library. In fact, the library floor was the equivalent of almost two other floors in height.

I regret that we shall be unable to give the Department of Pathology the new teaching and research laboratories which were planned for the new building and simultaneously return to the Department of Anatomy the Anatomy Building which it occupied exclusively from the time of its construction in 1912 until 1920. We believe, however, when this building is adequately remodeled and modernized, as proposed in the University's building program, that the Departments of Pathology and Anatomy can continue to function reasonably satisfactorily in this building.

The four floors for research—that is the two floors for cancer biology, the floor for biophysics and the floor for histo-cyto-chemistry—will be housed in a new unit to be constructed along Washington Avenue, adjoining Millard Hall and the Anatomy Building (Fig. 4). The funds for the construction of these floors in the Mayo Memorial were provided by special grants, and we were able to secure authorization to transfer these funds to this new building, the construction of which will be much less expensive than the tower would have been. The plans for this building are being prepared, and we believe that the building will be completed before the Mayo Memorial.

This program, as you doubtless have noted, leaves out completely the Medical Biological Li-

brary. Actually, before the plans for the Mayo Memorial crystalized, the faculty voted that provision for the medical-biological library on the medical campus was a top priority need for the Medical School. As it appeared then that there might be federal funds to aid public building following World War II, we had prepared plans and specifications for a medical biological library to be located in the vacant corner between the Anatomy Building and the Medical Sciences Building. Actually, this location for the library, since it will serve the College of Dentistry and the departments of zoology and botany as well as the Medical School, is in some regards preferable to the tower location.

The architectural perspective of this new building, prepared about eight years ago, is shown in Figure 5. Incidentally, this building also provides for a pathological museum, which was to have been housed in one of the floors of the department of pathology in the Mayo Memorial tower building.

As plans and specifications for this building are all completed it is our hope that it will be possible to obtain funds for its construction within the next couple of years. If this can be done it should be possible to complete this important unit not long after completion of the Mayo Memorial.

Future Plans and Problems

This completes my report for the College of Medical Sciences but, lest everyone think the picture is all rosy, I should mention some of our problems. These problems, as you doubtless have guessed, are mostly financial.

The most serious problem of all is basic support. Over the years, the Legislature has done very well by the University, but inflation and rising costs are giving rise to serious problems both

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as to staff salaries and to operating expenses. There frequently is not a great deal of difference budget-wise between a first-class institution and a mediocre one. And we just must improve salaries if we are to attract and retain the type of

sity Hospitals way below what will be needed for effective operation of these units. It is my hope that while the Mayo Memorial is under construction, we shall be able to obtain special gifts for scientific and other types of equipment needed for



Fig. 5. Architect's drawing of the proposed Medical Biological Library.

faculty which makes Minnesota the quality of institution that it is. We also must increase budgets for other operating expenses.

Another problem ahead is that, in order to provide funds for the construction of the Mayo Memorial, it was necessary to reduce funds for equipment and for the remodeling of the Univer-

sity Hospital. The securing of funds for other than military purposes is not easy these days, but it can be done and I am sure that we can look forward with optimism to the years ahead—years which I am sure will produce achievements in which we and our University can take continuing pride and satisfaction.

PRESENTATION OF ACHIEVEMENT AWARDS

J. L. MORRILL

President, University of Minnesota

Too often there is a kind of short-circuit in communication when the stay-at-home patriot stands up to praise the front-line soldier.

The patriot is full of generous sentiments, but he fails to express them in a way that means anything to the soldier who still sees and hears the sights and sounds of battle. One writer has put it this way: To a fighting man, words like courage, glory, valor and heroism sound hollow and meaningless beside the concrete names of battlefields and towns, the numbers of regiments, roads and bridges.

This inability to say the right and proper thing troubles me in saluting those to whom we would pay tribute tonight—the alumni and staff and faculty of our College of Medical Sciences.

Engraved in your minds and memory must be

countless victories in the struggle with death and disease and human disheartenment. Your triumphs are recorded in the special language of your profession: in case histories, in learned journals, technical volumes and laboratory reports. Your work becomes widely known only when you have concluded the patient work of investigation, experiment and compilation and emerge into the light of publicity with some gift of life to offer.

But what merits highest praise is the day-to-day regimen of scientific discipline which you impose upon yourselves. All this we, your patients and laymen, cannot share or really understand. We are handicapped in expressing our respect and appreciation. I can only declare the pride and gratitude which the University, the state, and the nation feel in the great work which you, and

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your predecessors, have accomplished and continue to accomplish.

Perhaps the reward most meaningful to a scientist is simply to give him a place to carry on his work; to place at his disposal the means and opportunity which will allow him to make his best effort. This is the kind of tribute which best reveals true understanding of what he is trying to do.

Through the years, the medical scientists of the University of Minnesota have earned many such tributes. Our medical facilities have been increasingly expanded by grants, by gifts and memorials from the State, from Federal agencies, from private organizations and from generous individuals.

The latest additions—the Mayo Memorial Medical Center and the Variety Club Heart Hospital—are clear-cut expressions of widespread faith and confidence in the University of Minnesota's community of medical men and women.

These new buildings were made possible by the contributions of many loyal partisans in the cause of human welfare. Almost every agency of a democratic society has participated in their creation. The Mayo Memorial is founded on appropriations from a generous state legislature; additional funds have come from Federal agencies—through the Hill-Burton Act, the National Cancer Institute, and the National Heart Institute of the U. S. Public Health Service; from the American and Minnesota Cancer Societies and from thousands of individual donors.

Most of you know the moving story of the Variety Club Heart Hospital at the University of Minnesota; how it was sponsored by a colorful association of showmen; how organizations and people from all walks of life joined in the work to bring it to fulfillment. The Heart Hospital is now in full operation. It is splendid with vivid colors and flooded with daylight—in harmony with the bright promise it holds for those who come there under a cloud. All of this only serves to illustrate a fact which must be a source of great pride. It is this: Minnesota Medicine has attained more than scientific stature; it has attained human stature, the goal of all your endeavor.

This faith in our College of Medical Sciences is promoted, not only by what is done here in the University Hospitals and laboratories, but through the influence and achievements of our distinguished alumni all over the world. Tonight, we honor some of them. Some are noted for their leadership in research and treatment. Some are outstanding for their work in some phase of public health.

This is a taken-for-granted term today—public health; and we tend to accept as commonplace the significance of the term. But there is nothing at all commonplace, nothing that can be taken for granted, in the idea which is implicit in the

term "public health." Actually, public health is a relatively new social and humane concept. Its province is to secure a fundamental right of mankind—the right to physical and mental well-being. Indeed, this right is prerequisite to the full enjoyment of all of our other rights.

Rudolf Virchow, the great German pathologist of the 19th century, who was also an astute diagnostician of social ills, made the strange statement that "Medicine is a social science, and politics is nothing else than medicine on a large scale."

In these broad terms, we see the relationship of medicine to society. It is this: In pursuing its own proper ends, medicine pursues the ends of social and human welfare. Dr. Henry E. Sigerest of Johns Hopkins said the same thing more practically in recommending a public health program for adoption by all the civilized countries in the world. He advocated:

"Education for all, including health education; the best possible working and living conditions; the best possible means of rest and recreation; a system of health institutions and medical personnel, available to all, responsible for the people's health, ready and able to advise and help them in the maintenance of health and in its restoration when prevention has broken down; centers of medical research and training."

This is the challenge confronting those who prosecute research and who strive to spread its benefits through professional service and programs of public health. Societal response to this challenge is plainly discerned in this country and in other areas of the world.

It is one of the purposes of the "Outstanding Achievement Awards" to express the University's appreciation to the alumni of the College of Medical Sciences who have been instrumental in making such progress possible.

Many of the recipients have already been honored in other places and in other ways. Their work is well known to most members of this audience.

Recognition of scientific attainment, indeed, is not so long in coming today as at one time it was. In the seventeenth century Thomas Hobbes wrote of his friend, Dr. William Harvey: "He is the only man, perhaps, that ever lived to see his own doctrine established in his lifetime." The doctrine, of course, was Harvey's new teaching on the circulation of the blood.

Times have changed. Nowadays, it is difficult to keep abreast of the medical attainments which merit praise. But we can begin to catch up on our own obligations, at least, this very moment. It is now my happy privilege to present the awards through which the University endeavors to acknowledge, with admiring respect and appreciation, some of its outstanding alumni in Medicine and Public Health.

In asking the first recipient to come forward, I shall read the full text of the certificate—reading thereafter simply the individual citations.

DISTINGUISHED ACHIEVEMENT AWARDS

The Regents of the University of Minnesota
As a Token of High Esteem and
In Recognition of Noted Professional Attainment by

FRED L. ADAIR

Distinguished Graduate of the University of Minnesota
Emeritus Professor of Obstetrics and Gynecology of the
University of Chicago
Nationally Honored for His Work in Reducing Maternal
Mortality
Deem Him to be Worthy of Special Commendation for
Outstanding Achievement
Conferred on October Eighth, Nineteen Hundred and
Fifty-one

* * *

FRANK E. BURCH

Distinguished Graduate of the University of Minnesota
Emeritus Professor of Ophthalmology in its College of
Medical Sciences
Pioneer in the Movement for the Prevention of Blindness.

* * *

EARL R. CARLSON

Distinguished Graduate of the University of Minnesota
Internationally Known Neurologist, Writer, and Lecturer
Unstinting Worker for Advancement in the Study
and Treatment of Cerebral Palsy.

* * *

ALBERT J. CHESLEY

Distinguished Graduate of the University of Minnesota
Executive Officer of the Minnesota State Department of
Health
Loyal Supporter of Public Health Education in the
University
Elder Public Health Statesman of the Nation.

* * *

ARILD E. HANSEN

Distinguished Graduate of the University of Minnesota
Professor and Chairman of the Department of Pediatrics
and
Director of the Child Health Program of the University
of Texas
Nationally Respected Authority on Rheumatic Fever.

* * *

ALMA C. HAUPT

Distinguished Graduate of the University of Minnesota
Director of the Nursing Division of the Metropolitan
Life Insurance Company
Eminent Contributor to the Health of a National at
War and at Work.

* * *

HERMAN E. HILLEBOE

Distinguished Graduate of the University of Minnesota
Commissioner of Health, the State of New York
Outstanding Public Health Administrator
Significant Contributor to Tuberculosis Control.

JANUARY, 1952

PEARL L. McIVER

Distinguished Graduate of the University of Minnesota
Chief of the Division of Public Health Nursing of the
United States Public Health Service
Celebrated Nurse and Pioneer in the Federal Health
Services.

* * *

JAMES E. PERKINS

Distinguished Graduate of the University of Minnesota
Managing Director of the National Tuberculosis Associa-
tion
Noted Epidemiologist and Administrator
Valued Adviser in International Public Health Planning.

* * *

EDITH L. POTTER

Distinguished Graduate of the University of Minnesota
Professor of Pathology of the University of Chicago
Renowned for Research in Diseases of the Newborn and
for Investigation in the Rh Problem.

* * *

WILLIAM P. SHEPARD

Distinguished Graduate of the University of Minnesota
Vice President of the Metropolitan Life Insurance Com-
pany
President of the American Public Health Association
Wise Administrator, Teacher, and Leader.

* * *

ALBERT M. SNELL

Distinguished Graduate of the University of Minnesota
Senior Internist, Palo Alto Clinic, Internationally Ac-
claimed for His Research in Gastro-enterology
Inspiring Teacher of Internal Medicine.

* * *

EDWARD L. TUOHY

Distinguished Graduate of the University of Minnesota
Chief of Medicine of the Duluth Clinic
Steadfast Exemplar of the Highest Standards in Medical
Practice
Crusader for Study and Research in Geriatrics.

* * *

Unable to be present but approved for Out-
standing Achievement Awards by the Regents of
the University were:

RAYMOND B. ALLEN

President, University of Washington, Seattle, Washington.

GEORGE O. BURR

Head of the Department of Physiology and Biochemistry,
Experiment Station, Hawaiian Sugar Planters Associa-
tion, Honolulu, Hawaii.

OLAF J. HAGEN

Physician, Fargo, North Dakota, and Former Member
Board of Regents, University of Minnesota.

C. J. VAN SLYKE

Director, National Heart Institute, United States Public
Health Service, Washington, D. C.

PRESENTATION OF PORTRAIT OF DEAN DIEHL

E. T. BELL, M.D.

Emeritus Professor of Pathology

This occasion is in no sense a farewell party to the Dean, but rather an occasion for rejoicing. Sixty years is not advanced age. I wish I were sixty again.

Perhaps I was chosen to make this presentation because I am one of the few among us who can remember when Harold was a boy. It may have been because I can sing his praises without fear of being accused of currying favor. My present salary cannot be adjusted up or down. I would like to believe that I was given this honor because I have known Harold and have been closely associated with him throughout his academic life.

He began his graduate career as a pathologist—a circumstance which to me indicates an early maturity of judgment. He directed the Student Health Service from 1921 until 1935, and under his leadership the Health Service gained the confidence of the students and the community.

Since 1935, he has been Dean of Medical Sciences and under his guidance our Medical School has become one of the best in our country, both in teaching and research. He believes in good teaching and he also does his best to promote research. He has welded us together as a friendly co-operative group. It is a joy to all of us to congratulate him on his long successful career.

I have said some other things about our Dean which are printed on your programs. Some of my discourse was deleted to make room for his picture which you see on the program. But after viewing this alleged likeness of the Dean, I think it would have been better to have had more remarks and less picture.

I am afraid, Mr. Morrill, that you regard this present which we are about to give you somewhat of the nature of a husband's gift of a box of cigars to his wife. We hope you will give it back to us. If you should do so, we shall hang the portrait in some appropriate place in the New Mayo Memorial Building. I should not like to put it among the Dean's bewhiskered predecessors who now adorn the Faculty Room in Millard Hall.

REMARKS IN ACCEPTANCE OF PORTRAIT

PRESIDENT J. L. MORRILL: Dr. Bell, Dean Diehl, ladies and gentlemen, I am happy, indeed, to accept this splendid portrait in behalf of the University.

Surely, this expression of respect and regard on the part of your colleagues must be heartening and rewarding to you, Dean Diehl, and to Mrs. Diehl, as it deserves to be.

The integrity and prestige of our University, as all of us know, are the sum of the productiveness and the

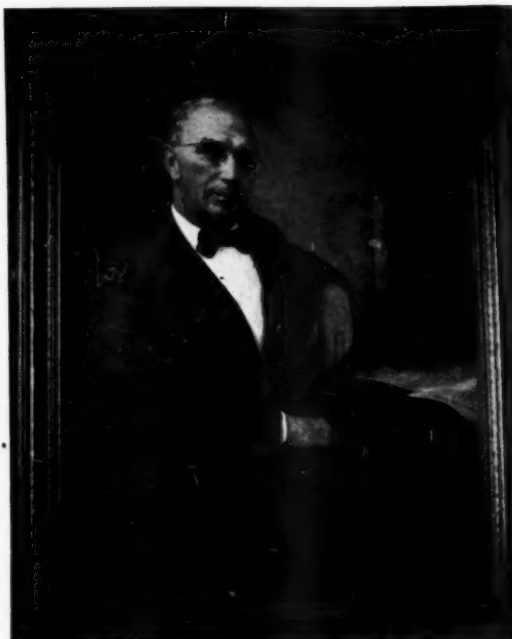


Fig. 6. Portrait of Dean Harold S. Diehl presented to the University of Minnesota by the Medical Faculty, October 8, 1951.

Perhaps we shall start a new series of Super Deans who do not possess hirsute adornments.

If any difficulty should develop about finding a proper place for the portrait, there will always be room for it in the Bell Museum. I rather favor this idea. Some people regard Pathological Exhibits as somewhat depressing, and a portrait might liven up the exhibits.

Mr. Morrill, it is now my privilege on behalf of the Medical Faculty to present to the University a portrait of Dean Diehl. It is a tribute to the best Medical Dean Minnesota has ever had, and even more importantly it is a token to Harold and Julia of our deep affection.

distinction of the individual staff members—inspired and assisted by far-sighted and energetic leadership. Dean Diehl, indeed, has brought leadership of the highest order to the College of Medical Sciences and thereby to the University of Minnesota.

On behalf of the Regents, I am delighted to receive, Dean Diehl, from your colleagues, this manifest and living memorial of your devotion and achievement.

MINNESOTA MEDICINE

PRESENTATION OF PORTRAIT OF DEAN DIEHL

DEAN HAROLD S. DIEHL: I am most deeply touched by the honor that you have paid me here this evening. But before speaking of that, I cannot resist telling you of an incident of which the unveiling of my portrait reminded me. This occurred in Washington at the unveiling of a marble bust of Justice Holmes, done by a famous sculptor. After the ceremonies, an attractive young woman came up to Justice Holmes and said that she had always been an admirer of his and that she had travelled all the way from California to be present at the unveiling of his bust. Justice Holmes replied that he was flattered, indeed, and that he would be glad to return the compliment at any time.

One other thought in a light vein is that it is a well-established University custom that portraits of deans are presented at the time of their retirement. This being true, if I were a person to look for ulterior motives, I might suspect that the presentation of my portrait at this time is a subtle suggestion that I might take appropriate action to conform to University custom. Actually, however, if that is the intent, you will have to be much more direct and blunt, because, like George Grim, "I Like It Here." And liking it, I hope to be around for a few more years.

Another thought, Mr. President, about this last item on the program, that is quite embarrassing to me, is that it indicates how little control I have over my faculty. We planned this meeting to make the distinguished achievement awards to our alumni, and I appointed a committee to arrange for the meeting with definite instructions as to what they were to do. The program was to end with Dr. Bell's talk, and he was to speak about the Medical School and anything else that he might wish to discuss with our distinguished guests. Then, without even consulting me, the program was changed. This, of course, is in evidence of complete disregard of administrative authority. It is a type of action that in the Navy might even be called mutiny. This, to me, is most embarrassing and may be indicative of an ominous trend. However, believing that their intentions were good and being much pleased with the end result, I shall not prefer charges against them.

Seriously though, my colleagues and friends, I am deeply appreciative of your expressions of confidence and good will, more appreciative than I can possibly put into words. With you, I am proud of the progress that our Medical School has made during my period of administration. In all honesty, however, I can take very little personal credit for this because I have had help, encouragement, and support from all sides. There was little, if anything, that I accomplished alone.

First of all, I want to acknowledge the credit that rightly belongs to Mrs. Diehl. For thirty years she has not only made a splendid home for our family but also

has helped, encouraged and supported me in my work. At times, she has even needed me a bit to get things done. She has been superb, not only as a companion but also as your Dean's wife.

Also, over these years, I have had the good will, the understanding, and the support of the central university administration. President Coffman, President Ford, President Coffey and currently President Morrill, by their wise counsel, encouragement, and support, made it possible for us to move continuously forward. The same is true of Mr. Middlebrook, Mr. Willey, Mr. Lunden, and others of the central administration. It has been true also of Dean Blegen, Dr. Balfour, Dr. Victor Johnson, in connection with our graduate training program. I have had the benefit also of the interest and the support of the medical profession and of many non-medical friends throughout the state. And finally, and most important of all, I have had the constant and unfailing help, loyalty and support of the faculty and staff. With such colleagues and friends, one could not fail.

From my point of view, the sixteen years I have served as your Dean could hardly have been more pleasant and more satisfying. We have had our problems and our disappointments as well as our achievements, but the disappointments have merely served to make our achievements more gratifying and our successes more sweet.

In this life, rewards do not come in any better coin than satisfaction in one's work and the esteem and affection of one's colleagues. I frequently wonder how I was so fortunate as ever to have had the opportunities which the University of Minnesota has given me over the past thirty years.

As I said before, "I Like It Here," and I appreciate more than I can possibly express, the honor you have paid me. I assure you that in my remaining years with the University I shall spare no effort to merit the confidence and good will which you have expressed here this evening.

In conclusion, I want to express my thanks to the committee that made the plans for the portrait and for this meeting; to Mr. Nunn, who so kindly and efficiently made and carried out the arrangements for this dinner; and to my colleagues and friends who made this portrait possible. I want also to express to Mr. Edward Brewer, the artist, my congratulations on this splendid portrait and my thanks to Mrs. Brewer for her enthusiastic interest and her many helpful suggestions. I am very pleased, Mr. Brewer, that the Committee selected you as artist to do this portrait.

Finally, this has been a wonderful evening for Julia and me. We do appreciate it and thank you.

Medicine is now threatened with a philosophy, a battle if you will, which involves the very survival of our democracy, our freedom, and our way of life. The zeal of those in high places, of certain elements in industry, in labor, and in our ancillary professions to correct social inequalities by nationalizing the profession of medicine can result only in the destruction of a system of medical care which is the envy of the entire civilized world. The ultimate result can be only the production of greater injustices than existed previously and the deterioration of the quality of medical care.

Socialism and communism flourish in times of economic hardship and distress. This ideology appears as

a panacea for the alleviation of temporary problems without due consideration for the long-term effects such doctrines will produce. The very essence of hope and a portent for the future lie in the revival of optimism in our reliance on the God of our fathers so beautifully expressed by that strong antagonist of atheistic communism, the Right Reverend Fulton J. Sheen, when in his Easter sermon in New York City he said, "In the providence of God, communism may be the fertilizer of a new civilization, the death that is spread over the world in the winter of its discontent to prepare the dead earth to tell its secrets in the new springtime of the spirit."—J. STANLEY KENNEY, M.D., Conference of Health Officers and Nurses, Lake Placid, N. Y., June 4, 1951.



ROGER L. J. KENNEDY, M.D.
President, Minnesota State Medical Association

President's Letter

OBJECTIVES OF THE COMING YEAR

I have often thought that the psychologic impact of the end of one year and the beginning of another, usually marking the start of new tenures for officers of groups such as the Minnesota State Medical Association, actually can create more problems than it solves.

Thus, each twelve months we have no choice but to close the books on the old year, despite the fact that some project or piece of business initiated in September or October, for example, has no logical reason for coming to an abrupt conclusion on January 1, and in fact often does not do so. Yet the tyranny of the mathematics in the calendar system requires the incoming president of the association to summon up his powers of prescience as best he can, to assay the weight and nature of coming events, and to embrace those measures which in his opinion will best serve the interests of the organization.

Such an assignment, in the face of twelve months yet to come, the import of which cannot be known by any man, is difficult indeed. There are, nonetheless, certain positive actions which can be carried out by any incoming officer, and I think they are valuable enough to be mentioned here.

First, I propose to learn as much as I can about the organizational structure of the Minnesota State Medical Association. This in itself is no simple task, for during the years we have created scientific and nonscientific committees, liaison positions and other posts or units which subserve a number of vitally useful functions, all subordinate to the business of maintaining the organization itself. It seems to me that a successful president of the association must have a thorough understanding of the duties and activities of each of the special groups I have mentioned.

Second, I shall endeavor to continue the close and cordial working relationship with the executive secretary of the association. Both the association and the public at large derive great benefits from the efficient work carried out day by day in the office of this eminently useful representative of our membership.

Third, I shall attempt to familiarize myself as extensively as possible with the twin-edged problem of ascertaining, primarily, what the health needs of

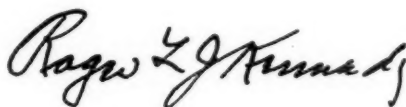
PRESIDENT'S LETTER

the community actually are, in as many aspects as is feasible, and, next, in careful study of what methods can be used to satisfy, in equitable measure, those needs. The fact that this problem currently is being accorded, as it has been for some years, intensive study on a national scale only emphasizes the magnitude of the task, even within the confines of a state.

The fourth objective I have in mind will, in some measure, contribute to progress in solution of the problem implied in the third. That is, the planning and presentation of a scientific program which embodies the latest advances in the fields of medicine concerned, as well as current additions to knowledge in these fields, and will enable each member readily to familiarize himself with the utmost which can be done for his patient in a given case. This knowledge inevitably is reflected in better medical counsel and treatment within the community as a whole.

A factor which sometimes is forgotten is the great opportunity, within an association such as this one, for the perfecting of a sound and strong organization on the basis of the friendship and co-operative labors among the membership itself. It is a good and satisfying thing to know what ones colleague is doing, to realize that the counsel of his experience can be had at any time, and to consider that the bond of friendship within the organization actually has no limitations.

It would be a hardy man, indeed, who would maintain that all the foregoing objectives can be fulfilled within the space of a single year, but progress in the direction of any one of them would be an achievement well worth while. Without in the least wishing to expose myself to the possible charge of presumption, I nevertheless hope that the sympathy, patience and understanding of the membership, combined with the best efforts of which I am capable, will in the end provide all of us with some cause for pointing to a degree of progress in 1952.



President, Minnesota State Medical Association

Editorial

CARL B. DRAKE, M.D., *Editor*; GEORGE EARL, M.D., HENRY L. ULRICH, M.D., *Associate Editors*

A MILESTONE

WITH THE ADVENT of another year we pause to look back on the year that has passed and at the same time look forward to the year 1952.

The past year saw a reversal in thinking in England manifest by the return of the Conservatives under Churchill to control of the government. Socialism has not worked for a betterment of social and economic conditions in England.

The United States has been following England down the road to Socialism. To obtain a vivid picture of the true state of affairs, those who failed to hear the addresses of Senators Taft and Byrd to the AMA House of Delegates in Los Angeles in December when they were broadcast to the nation, should read both addresses in *The Journal AMA* for December 15 (p.1576). No stronger criticisms of the road to Socialism being taken by the present administration can be imagined than these two speeches, the one by the Democratic Senator particularly. There is a growing realization very generally that the time has come to call a halt to deficit government spending and increasing taxation, if we are to avoid collapse. That the next year will be a crucial one in the history of our country seems to be very generally recognized. The same opinion is being voiced by Vogeler, the International Telephone and Telegraph representative in Hungary, who has returned to America after seventeen months in solitary confinement in Hungary. He is spending his time warning the people of this country of the danger threatening our freedom today, not only from Russian communism but from a powerful federal government which can ignore and has ignored the Constitution.

The AMA publicity campaign which, though undertaken primarily to prevent the socialization of the practice of medicine, actually spearheaded the attack on socialism in government, was successful in preventing compulsory federal sickness insurance legislation for the time being. The fight to prevent socialization of medical practice

and after that socialization of all other activities has only begun. The physicians of the country may feel proud of the part they have played so far and need not feel apologetic in their espousal of our so-called capitalistic system which assures individual freedom and initiative.

During the past years, medical schools and, in fact, most of the universities not supported by government units, have been unable to stay out of the red. To meet the distressing situation, the first thought with many has been to ask for federal aid. With a federal control of university finances, would and should go a share in the administration of the universities. This increase in the power of the federal government is just what is rightly feared. And if the federal government helps out the universities, a strong argument will be presented for federal aid to high schools, grade schools and other educational activities. The American Nurses Association at present is advocating federal aid for the training of nurses. With this policy the medical profession cannot agree.

In an effort to avoid federal subsidy of the medical schools, the American Medical Education Foundation was established by the AMA House of Delegates in December, 1950, with an appropriation of \$500,000 of AMA funds. An equal appropriation was made again in December, 1951. All funds raised will be funneled to a newer and larger organization known as the National Fund for Medical Education, which accepts contributions from a wider field in the hope of obviating the need for federal assistance. It is to be hoped that the year 1952 will see the successful outcome of this important undertaking.

MINNESOTA MEDICINE

FOR A GOODLY number of years, the secretaries of the state medical associations and the editors of the state journals have met in conference at AMA headquarters each year to discuss medical affairs. The two-day sessions have served to clarify medical problems and unify thinking as to public relations and policies.

For several years a meeting of presidents and officers of state medical associations has been held in advance of the annual AMA meeting each year at which a similar program was presented. Then again, the interim AMA meetings held the past three winters have been preceded by Public Relations programs similar in character. For this and possibly other reasons, the conference of secretaries and editors has been dispensed with.

In view of the fact that most of the state editors did not attend the meeting of presidents and officers of state conventions and feeling that a periodic get-together of editors is highly desirable, the AMA Trustees, at the instigation of the Advisory Committee of the State Journal Advertising Bureau, arranged for a meeting of editors alone in Chicago on November 12 and 13 last. It is the present plan to hold this meeting in Chicago biennially.

The many facets pertaining to the publication of a state medical journal received discussion. Being a professional journal its value depends largely on the content of scientific material. According to a survey reported at the meeting, clinicopathological conferences and case reports are most popular with the readers. Original articles, so-called, come next. These two departments comprise the backbone of the state journal and their quality determines the standing of the journal. It is difficult to determine how many subscribers read the editorials. That they are not read more often is doubtless the fault of the editors. That they are read to some extent becomes obvious when an opinion is expressed on some controversial subject. Editorials, however, should express opinions of the editor, rather than simply recite facts, as so many do. It is generally conceded that editors of medical journals should feel at liberty to express opinions on government policies but should refrain from taking side in partisan politics. Editors recognize that they cannot always be right and welcome attention being called to their mistakes or the expression of contrary opinions in "communications to the editor."

There is one department in a state journal which is distinctive—the personal or general interest column. All readers have an interest in what their friends and neighbors are doing. While the newsy quality of this department suffers from a necessary delay of some weeks in appearance in print, we urge county secretaries and, in fact,

all our readers to submit news items about themselves or acquaintances.

We desire more original articles, so-called, and more case reports. MINNESOTA MEDICINE affords an outlet for the 3,000 or more members of the State Association to present their ideas and experiences to their fellow physicians. Submitted articles should be brief and free from superfluous wordage. Articles on clinical phases of medicine are particularly desired. For a variety of reasons, we have been receiving fewer papers for publication and would appreciate the cooperation of members in this regard.

As we enter 1952, we wish our readers a very Happy New Year and again pledge our cooperation to the officers and membership of the Association. At the same time, we request the cooperation of the membership in making MINNESOTA MEDICINE bigger and better in every way.

NEW LAW REGARDING PRESCRIPTIONS

THE NEW LAW regarding the refilling of prescriptions under the Durham-Humphrey bill passed recently by Congress is sensible and a step in the right direction. It becomes effective April 26, 1952—six months from passage.

According to the new law, drug manufacturers will be required to label a drug as dangerous, which, "because of its toxicity or other potentiality for harmful effect or the method of its use, or the collateral measures necessary to its use, is not safe for use except under the supervision of a practitioner licensed by law to administer such drug," with the label "Caution—Federal Law prohibits dispensing without prescription." The druggist will require a prescription, written or given over the telephone, for the dispensing of a drug so labeled. The druggist must keep a file of telephoned prescriptions and check them back with the prescriber to be sure of his identity.

The definition of drugs limited to prescription, as interpreted by the Food and Drug Administration, includes among others: penicillin, barbiturates, benzedrine, dexedrine, sulfa drugs, antibiotics, thyroid and male and female sex hormones.

This clarifies the drugs requiring prescriptions, as far as the druggist is concerned. He can fill or refill others over the counter without prescription. This simplifies the prompt procurement of

medicine that requires a prescription which oftentimes was impossible formerly without breaking the letter of the law.

AMA PRESIDENT'S SCHEDULE

FOLLOWING is a three weeks' schedule of John W. Cline, M.D., president of the AMA, lifted from the November issue of the *Pennsylvania Medical Journal*.

September 9—Left San Francisco 7:45 a.m., and arrived in New York 8:55 p.m.

September 10—Left New York for New Haven.

September 11—Visited Yale Medical School followed by cocktail party and dinner at New Haven Lawn Club, speaking on "Problems Facing American Medicine in the Immediate Future." Returned to New York from New Haven.

September 12—Left New York 7:00 a.m., arriving in San Francisco 3:30 p.m.

September 13—Left San Francisco 8:55 a.m., and arrived in Reno, Nevada, 10:35 a.m. Presented two scientific discussions on surgical subjects at Nevada State Medical Society convention.

September 14—Spoke at Nevada Medical Society's annual dinner.

September 15—Left Reno 1:05 p.m., arriving in Los Angeles 4:35 p.m.

September 16—Left Los Angeles 2:25 p.m., arriving in St. Louis 10:30 p.m.

September 17—Attended convention of American Hospital Association; present at luncheon and spoke at dinner meeting.

We venture the opinion that this man-killing pace of flitting about the country, if maintained for the entire year of AMA presidency, will leave any man a physical and nervous wreck. Somewhere a brake should be placed on the demands made on our president.

Nowadays the AMA president is called upon to sacrifice his practice and convenience in the interest of unifying the national association and furthering public relations. Our presidents should know that their sacrifice for the good of medicine is appreciated.

KREBIOZEN

THE COMMITTEE ON RESEARCH of the Council on Pharmacy and Chemistry of the AMA on October 26, 1951, after a survey of 100 case histories of patients treated with Krebiozen, a secret cancer remedy alleged to have been discovered three years ago by Dr. Stevan Durovic, a former Yugoslavian physician, reported failure to confirm the beneficial effects claimed last March by Dr. Andrew C. Ivy, Chicago physiologist and vice president in charge of the professional schools of the University of

Illinois. The drug, described as a white powder soluble in water, is alleged to have been extracted from horse serum after the horses had been inoculated with an undisclosed substance. We are not informed whether this substance was undisclosed to Dr. Ivy and he administered a therapeutic agent the nature of which was unknown to him or whether he shared with the Yugoslavian physician in keeping the nature of the remedy undisclosed.

Had there not been an established agency to pass unbiased judgment on the efficacy of this alleged cancer drug, there is no telling to what lengths Krebiozen, with its presumably reliable backing, might have been used.

DOCTORS KENDALL AND HENCH HONORED

AT A DINNER meeting held at the Coffman Memorial Union ballroom, November 29, 1951, citations by the Regents of the University of Minnesota were presented to the two members of the faculty of the postgraduate medical school, Dr. Edward C. Kendall and Dr. Philip S. Hench.

As is well known, the biochemist Dr. Kendall and the internist Dr. Hench, both of the Mayo Foundation, along with Dr. Tadeus Reichstein of Switzerland, were presented with the Nobel Prize at Stockholm on December 10, 1950.

Dr. Kendall was born in 1886 at South Norwalk, Connecticut. From Columbia University he received the degree of B.S. in 1908, M.S. in 1909 and Ph.D. in 1910. In 1914, he entered the Mayo Clinic as head of the Division of Biochemistry, which position he held until his retirement in 1951. He was already well known for his isolation of thyroxine and has received numerous prizes for his scientific contributions. These include the John Scott Prize and Premium by the city of Philadelphia in 1921; the Chandler Medal from Columbia University in 1925; and the Squibb Award for 1945 for outstanding research in endocrinology.

He has served as president of the American Society of Biochemical Chemists and of the Association for the Study of Internal Secretions. He has been awarded the honorary Doctor of Science degree from Yale University, Western Reserve University, Williams College, the National University of Ireland and Columbia University.

In 1940, Drs. Kendall and Hench shared the Albert D. Lasker Award given by the American Public Health Association and in 1950 the Passano Award for the development of Compound E (Cortisone).

In 1950, Dr. Kendall was presented with the John Phillips Memorial Medal of the American College of Physicians, the award of the American Pharmaceutical Manufacturers' Association and the annual award of the Research Corporation of New York City.

In 1951, the two Mayo scientists were presented with the Award of Merit from the Masonic Foundation for Medical Research and Human Welfare and the

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\$10,000 Dr. C. C. Criss Award of the Mutual Benefit Health and Accident Association of Omaha, Nebraska.

Dr. Hench was born in Pittsburgh in 1896. He received his B.A. degree from Lafayette College in 1916 and his M.D. from the University of Pittsburgh in 1920. After a year's internship at St. Francis Hospital in Pittsburgh he became a fellow in medicine at the Mayo Foundation. In 1931, he received the degree of Master of Science in internal medicine from the University of Minnesota and became a full professor of medicine in the Rochester branch of the University of Minnesota postgraduate school of medicine in 1947. Part of his service in the army in World War II was spent as chief of the Medical Service and director of the Army's Rheumatism Center, Army and Navy General Hospital. He was promoted in 1945 to the rank of colonel.

Dr. Hench has received the honorary Doctor of Science degree from Lafayette College, Washington and Jefferson College, Western Reserve University, the National University of Ireland and the University of Pittsburgh.

One of the founders of the American Rheumatism Association, he was its president in 1940-41 and has been chief editor of the Association's annual *Rheumatism Reviews*. He is also chairman of the American Committee of the Ligue Internationale Contre le Rheumatisme and chairman of the Arthritis and Rheumatism Study Section of the National Institute of Health, United States Public Health Service.

Dr. Hench has a long list of honorary memberships in outstanding American and international scientific and medical societies. Besides sharing with Dr. Kendall the awards mentioned, he received the Scientific Award of the American Pharmaceutical Manufacturers Association and the special citation of the American Rheumatism Association.

The dinner meeting held at the Coffman Memorial Union in honor of Dr. Kendall and Dr. Hench was presided over by Dr. Theodore C. Blegen, Dean of the University of Minnesota Graduate School. The evening's program was initiated by the showing of a movie recording the presentation of the Nobel prize to the two Minnesota professors at Stockholm last December. Participants in the Symposium on Rheumatism held at the University under the cosponsorship of the University and the Minnesota Heart Association, who were

present, were next introduced. After the introduction of guests at the head table, an address on the University and Medical Research was given by Dr. Owen H. Wangenstein, head of the Department of Surgery at the University.

Dr. James L. Morrill, President of the University, on behalf of the Regents of the University, presented the special Regents' Citation as follows:

EDWIN CALVIN KENDALL

Distinguished chemist and physiologist, for thirty-seven years leader in biochemistry in the Mayo Foundation of the Graduate School of the University of Minnesota, successful investigator of hormones and metabolism, exponent of the creed of co-operation between laboratory and clinic, devotee to the thesis that progress in basic research is the key to improvement in human welfare—because your brilliant mind and tireless energy have brought surcease from pain and new hope to suffering men and have opened vistas into the unknown in knowledge; and because your career of scientific research exemplifies the ideal in the consummation of practical achievement through intellectual endeavor; the Board of Regents of the University of Minnesota, upon recommendation of its faculties, this twenty-ninth day of November, nineteen hundred and fifty-one, confers upon you, Edward Calvin Kendall, a Special Citation for Distinguished Service.

PHILIP SHOWALTER HENCH

Distinguished alumnus of the University of Minnesota, keen observer of disease-states, example of the ideal physician who combines the application of the available tools of science with the diagnostic skill and therapeutic yearning of the healer of the sick, exponent of teamwork in the investigation and practice of medicine—because your brilliant observations and tireless persistence in the study of rheumatic diseases have culminated in the discovery of new and successful methods of their treatment and of new knowledge as to the mechanism of their occurrence; and because your career as physician and clinical investigator exemplifies the ideal to which others may look for inspiration; the Board of Regents of the University of Minnesota, upon recommendation of its faculties, this twenty-ninth day of November, nineteen hundred and fifty-one, confers upon you, Philip Showalter Hench, a Special Citation for Distinguished Service.

After the citations had been presented, the recipients responded, each with a touch of humor which was delightful.

American medicine is spearheading the fight against those who would lead us into socialism and the welfare state. We all have a great task to further, jointly, our efforts to maintain a free America. We are on the threshold of the greatest progress, perhaps in all history, in the relief of human suffering and the prolongation of human life. The wonder drugs, the developments in the fields of hormone and steroid therapy, modern surgical miracles, all presage a great era of sound health for our people. The hidden workings of the human mind are

being revealed. And all this has, in the past, and can, in the future, be effected only if we maintain that spirit which flourishes only under our system of free and unfettered medicine. American doctors accept their obligations to the welfare of our free society, and with God's help will continue to uphold those ideals which have made this nation the hope of freedom-loving people everywhere.—J. STANLEY KENNEY, M.D., Conference of Health Officers and Nurses, Lake Placid, N. Y., June 4, 1951.

AN EDITOR VIEWS MEDICINE

EDWIN F. ABELS

Publisher, The Lawrence (Kansas) Outlook;
Past President, National Editorial Association

WHEN 65,000 individuals and business firms joined with the medical profession in buying advertising space in newspapers of America to advertise the fact that they were in accord with your campaign for freedom, my fellow publishers from one end of this great nation to the other took new courage. Here was unexpected support for the bulwark of Democracy, the non-metropolitan press of America, that has stood against the attacks on our freedoms. I speak of the non-metropolitan press that reaches more than 52 per cent of the people of this nation. Those newspapers that help elect 67 per cent of the U. S. Senators and 69 per cent of the U. S. Congressmen. I refer specifically to the papers printed and circulated in towns of less than 10,000 population and the rural trade areas.

It is literally true that groups of our editors met and talked about this phenomenon of an advertising campaign sparked by the medical profession. There is a logical reason for that surprise. Doctors are highly trained, scientific men. Colleges rightfully place great emphasis on thorough technical training. But some of your schools have entirely neglected a very important subject—that of public relations. Many an editor never hears from the doctor in his town except when the doctor's wife has a bridge party or when the banker's wife has a baby and "Doc" thinks he needs to be mentioned as having helped a bit. Let the editor suggest that "Doc" put his name in a small square on the Elks picnic program and the oath of Hippocrates gets a few modern oaths hooked on to it before the editor gets back to his office.

It has been said before, and I only repeat it, freedom in this nation is being poisoned. It is sick unto death. The editors of the papers I represent have known this fact and have been concerned about it. It never occurred to them to call in the doctor to help cure this case of poisoning. Foolishly, they kept calling on the politicians, some of the very men who were mixing the libation. What a thrill it was when you men walked in, unannounced, and told the world to count you on the side of freedom, liberty, private initiative and all of the privileges and opportunities that have contributed to the greatness of this nation. Yet it was the natural thing for you to do. History tells us that yours is a profession built by men of courage, vision and great intellect.

A History of Courageous Action

Let's check that very briefly by going back to the origin of true medicine as we know it today—back to that early Greek civilization from whence came some of the greatest thinkers of all times. Starting with nothing except their five senses and keen interpretative faculties

they pooled their experiences to form the very beginnings of modern medicine. The sick gathered in the Temple seeking help. It was there that the first hygienic principles were developed and the importance of baths and diet were discovered. In 460 B.C., Hippocrates, the greatest of all the scholars, the philosopher, the son and grandson of physicians, upset many old traditions and dared to follow his own conclusions; an example of courage that has been emulated many, many times through the centuries.

Let's go over into Egypt for another great demonstration of courage. This time it was Ptolomy who made the noteworthy contribution. His dissections of the human body were the basis for the advancement of anatomy and physiology.

Next, to the Roman Empire in 130 A.D. to pay tribute to Galen, the greatest of the Roman doctors. One of his biographers says that he influenced the medical profession for 13 centuries. In my opinion his influence is still being felt, for he was the first to charge a fee of \$2,000.

Let's skip the Dark Ages—the time from about 200 A.D. to the beginning of the 15th century. Skip them because the signs today are pointing unmistakably to a crackup of the fundamental principles upon which this nation is founded. Let's admit our political mistakes and help search for a solution, for there is work for every courageous group, every thinking individual. I want to give you a little true story to show that brave men are constantly being trained in your profession. We have in our town the University of Kansas with one of the nation's outstanding schools of Medicine. According to the story, one of the medical students had acquired a reputation for being an exceptionally brave young man. He even admitted that he had an abundance of that particular virtue. His classmates became a bit bored with his bragging. An opportunity to test his courage came when he was being initiated into one of the medical fraternities. The event was planned carefully. It was nearly midnight when he was taken to a deserted farm house where he was led into an empty room back by the flickering gleam of an uncertain flashlight. On a rudely constructed bench of boards placed across a couple of logs was a cadaver. The brave young man was given a lighted candle and told to keep watch. He did not know that his silent companion on the boards had left this vale of tears while sitting in a chair and was now in a prone position only because he was tied down. The initiate sat quietly in his chamber of reflection listening intently as his companions started their car and drove away. All was quiet except for the ticking of his wrist watch and the sound of the Kansas wind as it whistled eerily about the place. Suddenly there was a crash. A large stone

Address made before the Conference of Presidents and other officers of State Medical Associations, Atlantic City, New Jersey, June 10, 1951.

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came through the window and bounced noisily across the floor. The young medic scarcely moved. Only the candle flickered a bit in the breeze. Next a huge black cat came bounding in through the broken window and the cadaver suddenly raised to a sitting position. The student spoke a bit sternly as he said, "Lay down, you damn fool, I'll put the cat out."

Gentlemen, we recognize in you the courage that is necessary to assist in regaining and preserving our freedoms. You have made a start. Let's not just sit there like the cadaver and wait for someone else to put out the cat. You are teamed with the power of the published word and paired with men who are alert to the growing threat. Chaucer, in his writings many years ago said, "The lyf so short, the craft so long to lerne." Each of us has been busy learning our business and life is so short that we must act now if we are to be effective.

What America needs today, what your profession and my business needs, more than any other one thing that I can call to mind, is men of courage to speak out fearlessly and courageously for what they know to be right. You did it in your advertising campaign and you inspired thousands of others to follow your example. By that campaign you won new prestige. Brave men must hold high the torch of liberty.

Our Duty as Citizens

Our American system of government is based on the right of the individual under the law. It is based upon the tenets of Christianity, the Ten Commandments, the Sermon on the Mount, the Golden rule—aye, on the very principles enunciated by Hippocrates a half century before the birth of Christ. Our system of government is based on reason and common sense and the dignity of man. Our churches are crowded with those who say they believe in the principles of Christianity. Our stores and our places of business are staffed with the folk who fill the pews on Sunday. Yet we are faced with the threat of state control, Socialism, Communism. Everything that is the exact opposite of what we profess to believe. Possibly the old blanket story still holds true.

Out on the plains of our great middle west this old story has long been a favorite. The proprietor at the crossroads store was a pious gentleman. He had numerous verses of scripture tacked up all over the place. He made it a rule that every time he made a sale he would quote a verse of scripture as he punched the buttons on the cash register to ring up a sale. One day a cattleman came in and asked for a saddle blanket. He had just bought a fine horse and a wonderful saddle. He told the storekeeper he wanted a blanket that would fit his new purchases, the best was none too good. The old merchant reached to the top of the pile and pulled off a blanket for \$3.95. That wasn't nearly good enough. He reached into the middle of the same pile and pulled out one for \$14.75. It, too, was not good enough. The third one, which was pulled from the bottom of the \$3.95 pile, was priced at \$32.25 and the cattleman bought. The old loafers grouped about the stove leaned forward to hear the verse of scripture when the old merchant

rang up the sale. Here is what they heard—"He was a stranger and I took him in."

The pressure under which we are working has kept us so busy that we have become strangers to what is happening in Washington, in our state capitals and even in our local units of government. Like the man who bought the blanket, we are being taken in. So rotten and corrupt has our government become on the national level that it was necessary to fire a five star general in order to divert the minds of the people from the graft and corruption that had been exposed by a congressional committee. A part of that expose of gambling and immorality can be traced back to your town and to my town, for how could there be a national crime syndicate, or gambling syndicate, without local outlets throughout the nation?

I mention this to emphasize the fact that we have not been alert to our duty as citizens. We have calmly accepted the type of government the politicians have wanted us to have, not the kind of government we have a right to demand. As a result of our reticence to speak out bravely for what we know to be right, every freedom we hold most dear is at stake. If you will pardon a couple of personal experiences I want to illustrate what I mean. Back in 1938 I published a story in my newspaper about a certain ultra liberal preacher in my town. I called him a Communist and, as a result, I had a \$20,000 libel suit on my hands. In spite of the fact that he had said in my office that he was a member of the Communist party, I was forced to get evidence to prove my assertion. How I got that evidence and the fact that the case never went to trial is interesting but not important here. I want you to know that within the past six months that same preacher was called before the courts of Ohio in a loyalty hearing. That hearing was necessary because he was at the head of one of the largest airports in the state of Ohio adjacent to one of the large industrial districts. It took thirteen years for the Government to get interested in this case.

The other incident I want to mention is that within the past four weeks a friend of mine returned from 24 years of missionary work in China. I wanted a story for my paper. I did not get it but I did get information from him that has made me realize that we, the people, have lost far more of our freedom than we dare admit. The reason I did not get this man's story was because he feared for the life of his friends who are still in China. He saw it happen before he got out of the country. He knew that one little story in a weekly paper just about as far away from China as it is possible to get, telling of the oppression under Communist rule would find its way back to that country in a matter of only a few days and the purge would follow.

I bring these two stories to you to emphasize the fact that we can no longer hide behind the excuse that we are too busy in our business or professions to be interested in politics. In 1938 a man boasted that he was a Communist, proud of it, and that this Government would be overthrown either by or through their work among the youth of America. Thirteen years later, Government authorities started checking on him. A loyal, Christian, American citizen dares not speak because his story would

bring death to friends on the other side of the world within a fortnight. How near are we to losing our freedoms when our enemy already has this much power?

The Role of National Groups

Hundreds of our newspapers are not yet alert to the menace of Socialized medicine and other Socialistic-Communist activities. Hundreds of your members will not speak out in defense of the freedoms they have used to such glorious and beneficial advantage. The same is true in almost every line of business and professional endeavor. Our people must be alert to the threat that is so close upon us and must do something about it. Your organization has made a start.

I am proud of the fact that just about a year ago the members of the National Editorial Association, as part of their annual convention held at Providence, Rhode Island, made a pilgrimage to Plymouth Rock for a rededication service. Representing some 5,500 non-metropolitan newspapers in all parts of the nation, they dedicated the services of those publishers to the principles and ideals upon which this nation was founded. They consecrated themselves anew to the fundamental freedoms of our nation.

It was not just by accident that you found willing hands to help carry your message to the American people. There is a reason why papers with less than 3,000 circulation carried 75 per cent of the tie-in advertising. These are the small town newspapers that are close to the lives and hearts of the people they serve. These same newspapers, today, in many states are leading the campaigns to make hospital facilities available for the young doctors they hope to bring into their communities. These are the newspapers that are actively concerned with government. These are the papers that publish the death notices of those brave boys who are dying on the battlefields in Korea in a war that cannot be won—where the emphasis is only on how many of the enemy can be killed. These are the papers in which the sympathy of the community is extended to the parents. Your representatives, Whitaker and Baxter, made a careful study of the field before they chose so wisely the media to be used in placing your message before the people of America. They concentrated on the group that has ever carried the torch in the fight for freedom's preservation, the vast majority of them placing service to their community and nation ahead of the dollars that might be lured into the cash registers.

Your friends, the publishers, have not stopped in their fight for better government. It is a never ending fight. In our Spring Convention held in New York City in April of this year the National Editorial Association, after the excellent address given by Dr. Louis H. Bauer, chairman of your board of trustees, passed the following resolution:

"Whereas we believe that an outstanding contribution, during the past year, to the cause of individual freedom and the maintenance of our American way of life has been the Nation-wide campaign by the American medical profession in behalf of freedom for both physicians and the cause of political freedom,

"Therefore, Be It Resolved that we do publicly commend the doctors of our country for their enlightened contribution to the American way of life; and do recognize this public service so ably performed by the American Medical Association, its Officers, its Board of Trustees, its Campaign Committee, and to Clem Whitaker and Leone Baxter, who directed the National Education Campaign of the American Medical Association."

The resolution was passed without a dissenting vote. Today, it is my honor and privilege to bring you greetings from our membership and to compliment you for your firm stand against the socialization of your profession. It is our sincere hope that other national organizations will follow the example set by the great American Medical Association and arouse their membership to the peril that is upon us. The philosophy of our enemies is to divide and conquer. They expect to take us one group at a time. It is the duty and most important function of every national association, whether it be lumber dealers, hardware merchants, men in the various fields of transportation, men in the professions, newspaper publishers, doctors or any and every other type of national organization, to make every effort to block any and all government encroachment on business. We must stand together as a unit when our liberties and freedoms are at stake. This was one of the main themes in the National Editorial Association convention held at Seattle just a few days ago and it has been stressed in practically every meeting of the association during the past decade.

The Spirit That is America

The spirit that is America, and the spirit we must preserve at all cost, is typified by this true story from my native state, Kansas. I would be remiss in my obligation as a citizen if I did not give at least one illustration of the thrilling leadership the medical profession has in Dr. Franklin D. Murphy, dean of the University of Kansas School of Medicine—leadership that helps men to help themselves, thereby gaining strength of character and unity of purpose. Under the date line of April 29 the people of my state were given the story of the opening of the \$30,000 hospital in Bird City, a community of 536 people in the high plains country in the northwest part of the state. For 10 years the people in that small community tried to get a doctor. Dean Murphy's rural health plan, that has had national recognition, was the means of solving their problem. The people of Bird City built their hospital by contributions of cash and labor. More than 100 families gave something. It took them four years to get the job done but they now have a modern building, fully equipped; it has a nursery, a surgery room, an X-ray room, rooms for the patients, a kitchen, reception room and all the rest. It's all paid for, it's tax free, for the use of all the people of that little community. Best of all, it has been leased for \$1 per year to Dr. D. Dan Ferguson, a 27-year-old graduate of the University School of Medicine who has been practicing there for almost a year. This story has been repeated a score of times in Kansas under the inspiration and guidance of Dean Murphy. In the same manner and

with the same spirit that our pioneer forefathers conquered the prairies and forces of nature to lay the foundation for a great state, so Dr. Murphy is today's personification of the Spirit that is America.

For a direct antithesis let's go to the May 7 issue of the *Saturday Evening Post* (the issue will be found in the waiting rooms of many doctors about a year from now) to the article written by Dr. Ernest M. Pippa, "I Was A Surgeon For The Chinese Reds," in which he quotes a leading Communist as saying: "We have dispensed with the sloppy humanitarian viewpoint that wastes valuable time and material on useless dregs of humanity merely because they are sick. We have only one interest and one duty: to keep fit those who are of value to our communist state. These are the ones who will get our attention and our best care. We are not interested in the people of China as they are now. They must die anyway before we can build a new China. To help them to prolong their lives by adequate medical care would not only be a waste but it would retard progress."

There you have the communist way in contrast to what we have enjoyed in this nation. It is true that socialized medicine alone is not communism as it is practiced in China, but we must recognize that it is a big step in that direction. Look what those who advocate socialized medicine did with the dignity of the ordinary bank loan when they launched the RFC.

I will admit readily that this illustration is a bit extreme but when we start down a road it is well to know beforehand just what is at the other end. We have had far too much loose thinking and social planning in this nation. Not knowing all of the facts gets us into trouble quickly. The favorite story of a former chancellor of our University concerned a student who objected to the requirement that he learn to swim. He said he had no time for it and said he could learn to swim by reading about it in a book and studying the pictures. The idea caught the fancy of the swimming instructor who consented to the student's demands and told him to report at the end of the semester ready to swim three times the length of the pool as a test of his knowledge. Two or three evenings before the time for the test the student practiced the various strokes as illustrated in his book by lying on the piano bench, kicking and going through the necessary motions. When the time came for the test he plunged bravely into the deep end of the pool and sank to the bottom. The second time he came sputtering to the surface they yanked him out of the water. When he regained his voice he said that he had committed to memory every necessary detail on how to swim and he would have been successful, too, except he didn't know about the looseness of the water. We have far too many persons who do not know about the looseness of the thinking in political circles.

Our Common Cause

Members of the conference, I ask your pardon for not having properly emphasized the many accomplishments of your great profession. Many of the cures that are now considered routine by you in your everyday work border closely on the miraculous. Never in all of recorded his-

tory has the healing art advanced so rapidly by scientific research that has been so basically sound. Much of that advancement has been due to your closely knit organization and exchange of ideas and experiences. Through your efforts during the past 50 years you have given us 20 extra years of life and it didn't just happen by accident. My grandson who was born three months ago can look forward to 67 years of life unless the Socialized medicine politicians steal it from him. I have heard the attacks on the medical profession in legislative halls and have helped to refute them. I am well aware of the criticism that is leveled at you sometimes justly but far more often unjustly. Mostly it comes because of too much professionalism and too little sympathy, kindness and understanding on the part of a busy doctor. But all of this is of minor importance compared to the main issue, socialized medicine: we want none of it.

I have purposely stressed the threat to our freedoms for that is our common cause. Within the past fortnight the same alarm has been sounded in three different state press meetings. In Minneapolis, Minn., Ralph Keller, secretary-manager of the state association and a competent leader, said: "a discouraging number of passes were made at the freedom of the press during the recent session of the Minnesota legislature. The trend is evident in legislation in both state and federal levels." A similar thought was expressed in a press meeting that week in Boulder, Colorado. Again at Elkins, West Virginia, Jim Weir, publisher and veteran association executive, stated it this way: "complacency, indifference and irresponsibility, a creeping disease, is to be seen on all sides, in all the levels. An alert press is not alone sufficient to protect us from the dangers from within and from without. A rebirth of responsibility and a resurgence of freedom is needed."

I am emphasizing today the need for the continued help of the Medical profession to bring about the rebirth of responsibility and the resurgence of freedom that my friend Jim Weir speaks about. I am also extending an invitation to all other groups and national organizations that believe as we do to join with us for we must be united if we win this fight. In far too many places there is a lack of effective leadership either in the medical profession or at the newspaper office. In those places it must come from some other group. Through our combined efforts we must somehow, some way, rekindle in the heart of every true American that spark of patriotism so necessary to good citizenship in our republic. We must never lose sight of the fact that free enterprise made America great and free enterprise will keep America great. We must speak up for America and her institutions at every opportunity. We must ever remember that what a man does for himself dies with him, but what he does for his community, his state, and nation lives on forever in the minds of his fellow men. We must do all within our power to preserve our constitutional form of government. We must live our daily lives to the honor and glory of God whose universal laws are the cornerstone of the nation we love. If we do all of these things, then you and I and those who follow can continue to enjoy the blessings of this great, liberty loving nation.

Medical Economics

Edited by the Committee on Medical Economics
of the
Minnesota State Medical Association
George Earl, M.D., Chairman

SENATORS WARN AMA DELEGATES OF STATE SOCIALISM

Senators Robert A. Taft and Harry F. Byrd charged that growth of Federal power perils individual liberties in America and is leading toward state socialism. This warning was voiced to the House of Delegates of the American Medical Association in its Interim Session in Los Angeles last month.

Scoring current trends of government control, Senator Taft said that the fundamental problem before Americans today is "how best to maintain the great progress they have made under liberty. That liberty is threatened by the forces of Communism from abroad and is threatened by growing Socialism and government control at home."

Explains Socialism Meaning

Today's liberty, Senator Taft continued, is threatened by "what is roughly called Socialism." He said:

"By that I mean the growing power of government in the affairs of all individuals and its increased activity in many fields where it has never heretofore been involved."

He described the increase in government controls by saying that in 1931 the Federal Government conducted 6 per cent of the country's activity. In 1949, before the start of the mobilization program, Washington was spending 10 times as much money as in 1931 and was conducting 18 per cent of the activity. By 1953, he estimated the Government will be spending 38 per cent of the total income.

"It has undertaken to regulate all industry and commerce and agriculture with great Federal bureaus and huge subsidies. It has taken over functions which were almost exclusively local and it threatens to take over all welfare services through a scheme known as social insurance, which is not insurance but simply more taxation to support free Federal welfare services."

Lauds AMA's Stand

The senator applauded the AMA's efforts to halt the socialistic trends in America, adding that "the doctors are justified in this because the key move of the socialists today is the effort to set up a Federal system of socialized medicine."

"The Government proposes to collect six or seven billion dollars, mostly in payroll taxes from workmen, and set up a vast Federal bureau to employ nearly all the doctors in the country to furnish free medical service to all the people, including the great majority who are perfectly able to pay for it themselves . . .

"We cannot impose on the hard-working people of the country a burden so great to support the non-workers that it reduces their incentive and their standards of living."

Socialism Has False Blueprint

Senator Taft asked the purpose of this vast expansion of government activity, answering that supposedly it is for the welfare of the man of low and middle income. "Socialism draws a beautiful blueprint, but it utterly destroys the incentive of the individual manufacturer or the individual workman," he said. "In its efforts for equality, it reduces everyone to the dead level of mediocrity. New ideas are discouraged."

"The more powerful a government becomes, the stronger its propaganda in behalf of more power. The trend cannot be stopped unless you are willing to elect both a President and a Congress who believe that the maintenance of liberty is the first and most essential consideration for progress."

Byrd Cites Fiscal Weakness

Senator Byrd of Virginia told doctors that the "one overshadowing characteristic of the administration now in Washington is fiscal weakness and irresponsibility. From this springs the demand for confiscatory taxes, stifling controls and centralization."

Stating that the administration is guilty of great fiscal irresponsibility and that it is being further exploited by political camp followers who would centralize all power and purse control in Washington, Senator Byrd warned:

"From these come a deadly assault on the free enterprise system, the creeping socialism and the scandals which Thomas Jefferson foresaw when he said: 'I believe that a consolidated government would become the most corrupt government on earth.'"

Senator Byrd said that America's most inflated item today is the Federal Government itself, and continued:

"Inflation is conceived and born in Washington. Only the Federal government can spend in unlimited amounts. It alone determines the value of money and the extent of credit. A Federal bond is a first mortgage on all the property owned by every American citizen.

"Once the American dollar goes down, we will enter an age of international darkness. The American dollar is the only thing today that is holding the world together.

"What nation can carry the standard if we fail? Without its light, freedom and progress would perish from the earth. We must not fail."

HOUSE OF DELEGATES REVISES HESS REPORT

The House of Delegates of the American Medical Association, at its December interim session, adopted a policy statement on physician-hospital relations which supplants the controversial "Hess Report." The following principles for guidance of individual practitioners and medical societies in controversies over employment of doctors by hospitals were set forth:

1. A physician should not "dispose of his professional attainments or services" to any hospital or institution under conditions whereby such services are resold.

2. If a hospital does not sell the physician's services, the financial arrangement between them may be placed on any mutually satisfactory basis. Remuneration may be made for teaching or research not only by hospitals but by corporations and other lay bodies.

3. Specialties of anesthesiology, pathology, physical medicine and radiology—the ones chiefly concerned by this AMA policy—are recognized as an integral part of medical practice.

Half Million More to Medical Schools

The House of Delegates also voted to contribute another \$500,000 to the American Medical Education Foundation, which has been raising funds within the organization for the unrestricted use of the nation's medical schools.

Approximately \$640,000 has been turned over

so far by the Foundation to the National Fund for Medical Education. This money, 56 per cent of the amount dispersed by the Fund, was divided among the seventy-nine approved medical schools for use at the discretion of the deans of the institutions.

MEDICAL SERVICE CONFERENCE DATES SET

The National Conference on Medical Service will hold its annual meeting at the Palmer House, Chicago, on Sunday, February 10, 1952. Harlan English, M.D., Danville, Illinois, is this year's chairman, and the Illinois State Medical Society is acting as host.

The tentative program is as follows:

AMERICA'S NEXT SOCIAL AND HEALTH CRISIS

- I. Care of the Aged with Chronic Disease
 - (A) Size of the Problem—to be presented by an outstanding insurance actuary
 - (B) One Partial Solution—to be presented by a representative of a city welfare department

Luncheon

"Our Citizens and Their Doctors"—HON. EVERETT MCKINLEY DIRKSEN, U. S. Senator from Illinois
- II. Veterans' Medicine
 - (A) "Future Implications of Veterans' Medical Care"—GEORGE CRAIG, Past Commander of the American Legion
 - (B) "Unusual Problems in Veterans' Medical Care"—ADMIRAL JOEL T. BOONE, Chief Medical Officer, Veterans Administration, Washington, D. C.
 - (C) "Hometown Veterans' Care—A Success or a Failure?"—(Speaker to be announced)

BRITISH M.D.'s CALLED "ARM OF GOVERNMENT"

The piquant phrases of the *Wall Street Journal* have once again been used forcefully to bring out the underlying truths in the latest request of British doctors that the government fine any patients who fail to take the doctors' pills. *The Journal* feels that this step is perfectly logical since "these doctors are just as much an arm of the British government as the bobby on the street corner. They are paid by the government to regulate the public health just as the bobby is to regulate traffic. In either case if the citizens don't carry out instructions the orderly plans are snarled up."

Cannot Shirk Duty

Describing the National Health Service as having gone so far as to take on the duty of running part of the citizens' affairs, the *Journal*

decides that the health service cannot shirk its duty, and so it must also regulate a penalty for not obeying any rules established:

"It's a well established principle that when a government takes on the duty of running any part of its citizens' affairs it is necessary and proper for the government to use its powers of compulsion to see that the people do what the government knows they should do. If the government has the duty to protect the people's health, it surely shirks its duty if it permits people not to take the pills ordered by regulations."

Thus, says the *Journal*, the British doctors are on sound judicial, historical and sociological ground. "And they are really being very reasonable about it. All they want the government to do is fine a patient 10 shillings (\$1.40) the first time he violates an order to stay in bed, eat milk toast or wear his government-provided false teeth. Even for a second offense the fine is to be only a pound (\$2.80). With commendable British restraint the doctors have refrained from asking for jail sentences."

In spite of the overtone of lightness in the *Journal's* comments, the serious meaning of the situation is clear, and can serve as an adequate warning to those who still think that a government-controlled health insurance program would be advisable for America. This odd proposal for compulsion has all the earmarks of socialistic logic. The *Journal* concludes:

"We are sure Parliament will act promptly on this request. It's hardly cricket for the medical planner to have the responsibility for regulating the patient's health without the authority to regulate the patient."

VOLUNTARY HEALTH PROTECTION

Reflecting the continuing desire of Americans to choose their own methods of meeting the costs of illness, all forms of voluntary health protection scored tremendous gains in 1950 to set new records, the Health Insurance Council reports in the fourth annual edition of its Survey of Accident and Health Coverage in the United States.

The council survey shows that hospital expense coverage was held by 76,961,000 persons at the end of 1950, a gain of 17 per cent over the figure of 66,044,000 estimated for the year previous. The number of persons protected under hospital coverage has more than doubled since the end of the war.

Surgical expense insurance gained 32 per cent from 41,143,000 to 54,477,000.

Medical expense coverage gained 28 per cent from 16,862,000 to 21,589,000.

The council estimates that the 1950 total was equivalent to coverage on approximately 60 per cent of employed civilian population. The figures do not include the individuals covered solely by government insurance under compulsory plans, but do include all insurance companies, Blue Cross, Blue Shield, fraternal societies, local medical societies, industry, universities and others. —Insurance Economics Survey, October, 1951.

JANUARY, 1952

THE MINNESOTA STATE BOARD OF MEDICAL EXAMINERS

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Saint Paul 2, Minnesota

Julian F. DuBois, M.D., Secretary

PROBATION OF MINNEAPOLIS WOMAN REVOKED FOR CRIMINAL ABORTION

Re State of Minnesota vs. (Mrs.) Val A. Ramer

On December 15, 1951, the probation previously granted by the Hon. Rolf Fosseen, Judge of the District Court of Hennepin County, on August 22, 1950, to Mrs. Val A. Ramer, seventy-seven years of age, 4311 Portland Avenue, Minneapolis, on a charge of abortion, was revoked. The defendant, Ramer, admitted to Judge Fosseen that she had committed two criminal abortions while she was on probation. Mrs. Ramer had entered a plea of guilty on June 6, 1950, to an information charging her with the crime of abortion. At that time, Mrs. Ramer also admitted a previous conviction in 1936. Judge Fosseen sentenced Mrs. Ramer on August 22, 1950, to a term of not to exceed three years in the Women's Reformatory at Shakopee, Minnesota, but, because of her age, suspended the sentence and placed Mrs. Ramer on probation for a period of five years.

Mrs. Ramer was arrested on November 28, 1951, following a routine visit to her home by an officer of the Hennepin County Probation Office. At that time, a young woman, who was found in the kitchen of Mrs. Ramer's home, ran outside and fled in an automobile driven by a young man. Various medical instruments were found on a tray in the oven of the defendant's home. Subsequent investigation by the Minneapolis Police Department, Hennepin County Probation Office and the Minnesota State Board of Medical Examiners disclosed that Mrs. Ramer, on November 28, 1951, had aborted a thirty-three-year-old St. Paul woman, who admitted that she was the person who had fled Mrs. Ramer's home on that morning. The same woman admitted that she paid Mrs. Ramer \$50.00 two weeks previously, when she first attempted the abortion. She had also been aborted by Mrs. Ramer six or seven years ago. The investigation also disclosed that the defendant Ramer had aborted a twenty-six-year-old unmarried Minneapolis woman on November 27, 1951, for which she was paid the sum of \$50.00.

The defendant Ramer was first convicted of the crime of abortion in 1936. On October 30, 1934, the grand jury of Hennepin County returned an indictment charging a Minneapolis physician and the defendant Ramer, with the crime of abortion. In April, 1936, the defendants were placed on trial and both found guilty of abortion. On May 5, 1936, each defendant was sentenced to a term of not to exceed four years, the sentences being stayed and both defendants placed on probation.

MINNEAPOLIS PHARMACIST CONVICTED OF CRIMINAL ABORTION

Re State of Minnesota vs. Meyer S. Furman

On November 26, 1951, Meyer S. Furman, forty-four years of age, 2797 Xerxes Avenue South, Minneapolis, was sentenced by the Hon. Harold N. Rogers, Judge of the District Court of Hennepin County, to a term of not to exceed four years in the State Prison at Stillwater, for the crime of abortion. Judge Rogers stayed execution of the sentence for two years, and placed Furman on probation. Furman, a registered pharmacist, operates the Grant Street Pharmacy at 1333 Nicollet Avenue, Minneapolis.

Furman and Mrs. Clara Olga Anderson, 1728 Bryant Avenue North, Minneapolis, were arrested in September

following an investigation by representatives of the Minnesota State Board of Medical Examiners and Minneapolis police officers. That investigation disclosed that \$350 was paid to Furman on September 7, 1951, for an abortion on a twenty-one-year-old Swift County girl. The abortion was performed by Mrs. Anderson, who admitted receiving \$150 of the money, with Furman pocketing the balance. Furman made the arrangements for the abortion, driving the patient to Mrs. Anderson's home from his drug store, and when no miscarriage resulted, the abortion was repeated on September 21, 1951, by Mrs. Anderson. Furman, who entered a plea of guilty on October 15, 1951, to an information charging him with the crime of abortion, admitted to the Court, prior to being sentenced, that he had referred three patients to Mrs. Anderson for abortions. Furman also admitted that he had been in previous trouble for selling liquor without a license. The records in the Municipal Court in Minneapolis disclose that on April 28, 1939, Furman paid a fine of \$100 for selling liquor without a license. On May 24, 1940, Furman was found guilty of selling non-intoxicating malt liquor without a license and was sentenced to ninety days in the Minneapolis Workhouse. Furman filed a notice of appeal but subsequently dismissed the appeal, and on September 30, 1940, entered the workhouse to serve his sentence. On February 12, 1949, Furman admitted, in a written statement to Minneapolis police officers, having referred "about twenty-five" girls to Martin Peter Schmit, who was sentenced on March 17, 1949, to a term of not to exceed four years in the State Prison at Stillwater for the crime of abortion. Furman graduated from the College of Pharmacy of the University of Minnesota in 1927. Furman's abortion activities have been called to the attention of the Minnesota State Board of Pharmacy.

Furman's co-defendant, Mrs. Clara Olga Anderson, entered a plea of guilty on October 23, 1951, to an information charging her with the crime of abortion. The Court referred her case to the Probation Office for investigation and the imposition of sentence was set for December 17, 1951.

MINNEAPOLIS WOMAN SENTENCED TO 8-YEAR TERM FOR CRIMINAL ABORTION

Re State of Minnesota vs. Clara Olga Anderson

On December 17, 1951, Hon. Harold N. Rogers, Judge of the District Court of Hennepin County, sentenced Clara Olga Anderson, fifty-three years of age, 1728 Bryant Avenue North, Minneapolis, to a term of not to exceed eight years at hard labor in the Women's Reformatory at Shakopee on a charge of abortion.

On October 23, 1951, Mrs. Anderson had pleaded guilty to an information charging her with the crime of abortion, and also with having had two previous convictions for a similar offense, one in 1943, and another in 1946. A plea by the defendant's attorney that the defendant be given probation was opposed by legal counsel for the Minnesota State Board of Medical Examiners and denied by Judge Rogers. Mrs. Anderson and Meyer S. Furman, 2797 Xerxes Avenue South, Minneapolis, were charged as codefendants with the crime of abortion in a complaint issued in September, 1951. Investigation by representatives of the Minnesota State Board of Medical Examiners and Minneapolis police officers, disclosed that the defendant Anderson had twice attempted to do an abortion on a twenty-one-year-old Swift County girl. Mr. Furman had made the arrangements for the abortion on both occasions and accompanied the girl to the defendant Anderson's home. A sum of \$350 was paid to Furman for the abortion, \$200 of which he kept himself and the remainder was paid to the defendant Anderson. When the girl later was hospitalized the case was called to the attention of the authorities.

The defendant Anderson has two previous convictions for the crime of abortion in the District Court of Hennepin County. After entering a plea of guilty on March 25, 1943, to an indictment charging her with the crime of abortion, Mrs. Anderson was sentenced to a term of not to exceed four years in the Women's Reformatory at Shakopee. However, the sentence was stayed on condition that the defendant serve one year in the Women's Detention Home and then Mrs. Anderson was placed on probation for a period of three years. Again on December 28, 1946, Mrs. Anderson entered a plea of guilty in the District Court of Hennepin County to an information charging her with the crime of abortion, and also having a previous conviction for abortion in 1943. On the same date she was sentenced to a term of three years at hard labor in the Women's Reformatory at Shakopee. Mrs. Anderson has no license to practice any form of healing in the State of Minnesota.

THE ECONOMIC VALUE OF HIGH QUALITY MILK

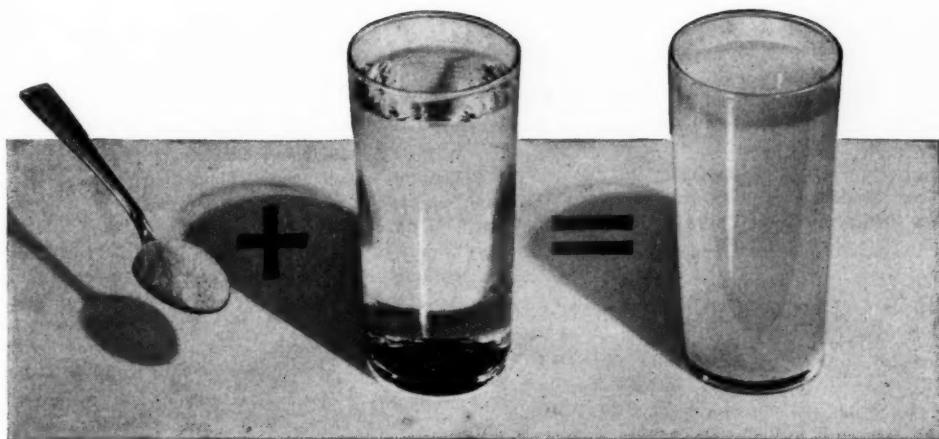
(Continued from Page 45)

recently said, "Of all the factors of man's environment, none is more important to his welfare than food. Of all foods, none is more important than milk." Nutritionists tell us that one-fourth of our daily food requirements should come from dairy products, yet studies of present trends in the per capita consumption of some dairy products show that we are not in all cases maintaining this one-fourth proportion. The consumer is the one who dictates the world standards, and if this quality is not maintained, the consumer loses interest in the product and looks for a substitute. The present Grade A regulation which is being promulgated in Minnesota was required by the demands of the public that Grade A dairy products be made available to them. In 1900 the average American had to work twenty-seven minutes to earn a quart of milk, and this quart was dipped from a can. Today he receives a safe high-quality product delivered with dependable service right to his home for only nine minutes of work.

High quality of dairy products has definite economic value to the public. The dairy industry affects a considerable proportion of our people, provides nearly one-third of our agricultural income and supplies one-fourth of our food supply. The perpetuation of this industry depends so much on the high quality of its products that no producer, the processor, the consumer and the doubt should be left in our minds of the tremendous economic value of high quality milk to the public.

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

◆ Reports and Announcements ◆

AMERICAN COLLEGE OF CHEST PHYSICIANS

The fifth annual Postgraduate Course in Diseases of the Chest sponsored by the Council on Postgraduate Medical Education and the Pennsylvania Chapter of the American College of Chest Physicians and the Laennec Society of Philadelphia, will be presented at the Warwick Hotel, Philadelphia, Pennsylvania, March 24 to 28.

A program covering the entire field of heart and lung disease is being arranged. Dr. Chevalier L. Jackson, Philadelphia, president of the American College of Chest Physicians, is chairman of the postgraduate course committee.

Physicians interested in attending the postgraduate course can communicate with the Executive Offices, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

AMERICAN COLLEGE OF SURGEONS SECTION MEETING

A three-day sectional meeting of the American College of Surgeons will be held at the Radisson Hotel in Minneapolis, Minnesota, on March 24, 25 and 26.

The program will include two days of scientific sessions at the Radisson Hotel and a day of teaching clinics and demonstrations in Minneapolis hospitals. Distinguished speakers will present papers, panels and symposia on current surgical problems, and extensive programs for specialists in ophthalmology and otolaryngology have been prepared for March 25. New surgical motion pictures will be shown, including several which were prepared especially for the Cine Clinics at the 1951 Clinical Congress, and also a stereoscopic colored film on radical resection for carcinoma of the stomach, which is attracting a great deal of attention wherever it is shown.

Dr. Harvey Nelson and his Committee on Arrangements have made extensive preparations to assure a good meeting and a warm welcome to Minneapolis for all visiting surgeons. Hotel accommodations may be obtained by writing to Mr. Neil Wilsey, Front Office Manager in Charge of Reservations, Radisson Hotel, Minneapolis 2, Minnesota.

SUMMER CAMP FOR DIABETIC CHILDREN

A summer camp for diabetic children will be opened for the fourth season under the auspices of the Chicago Diabetes Association, Inc., from July 1 to July 22 at Holiday Home, Lake Geneva, Wisconsin.

In addition to the regular personnel of the camp, there will be a staff of dietitians and resident physicians, trained in the care of diabetic children, furnished by The Chicago Diabetes Association.

Boys and girls, ages eight to fourteen years, inclusive, will be accepted at a fee of \$120 (which covers the

three-week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary.

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to the Service Unit, Chicago Diabetes Association, 110. South Dearborn Street, Chicago 3, Illinois.

CHICAGO OPHTHALMOLOGICAL SOCIETY

The Chicago Ophthalmological Society has announced that the fourth annual Clinical Conference will be held February 21 to 23 at the Drake Hotel. The first day will be devoted to surgical clinics at various Chicago hospitals. On the following days there will be symposia on cataract surgery and recent advances in therapeutics, followed by round table luncheons. Additionally there will be lectures concerning neuro-ophthalmology, ocular pharmacology, nystagmus, provocative tests in glaucoma and the secretion of aqueous.

Further information concerning the conference may be obtained from Miss Maud Fairbairn, 8 W. Oak Street, Chicago 10, Illinois.

POSTGRADUATE ASSEMBLY

Los Angeles' largest annually held medical meeting—the Postgraduate Assembly and Convention, sponsored by the Alumni Association of the College of Medical Evangelists School of Medicine—has been scheduled for March 2-4, 1952, at the Biltmore Hotel. This convention is termed the "best in the West."

The 1952 convention features such nationally prominent men as U. S. Army's Major General George Armstrong; Lahey Clinic's Drs. Sara Jordan, Martin Tracey and John Norcross; A.M.A.'s Secretary and General Manager Dr. George Lull; Joslin Clinic's Dr. Priscilla White; Cornell Medical School's Dr. Harold Wolff and Mayo Clinic's Dr. Giles Koelsche,* to mention some of the thirty-seven scheduled to lecture and take part in panel discussions.

Short courses in therapeutics, internal medicine, pediatrics, roentgenology, dermatology, psychiatry, surgery, otolaryngology, urology, proctology, anesthesiology, and obstetrics and gynecology are to be given on March 5, 6 and 7. Educators of the West's medical schools will serve on the faculty for these sessions.

For further information, write Evelyn R. Strachan, Managing Director, 312 North Boyle Avenue, Los Angeles 33, California.

*Giles A. Koelsche, M.D., will speak on "Current Concepts of the Treatment of Asthma."

Do You Have Investment Income?

First Investor: "I feel quite satisfied with my investments—last year I had an average return of about 5%."

Second Investor: "Well, I averaged about 3% with very safe investments, and the income is all mine."

First Investor: "I don't know what you mean—the 5% return is all mine, isn't it?"

Second Investor: "Aren't you forgetting to consider the federal income tax you must pay on your return? Even with this year's taxes your investment income will be under 3%. It may be less than that with next year's taxes."

First Investor: "What about the income tax on your 3% return?"

Second Investor: "My income tax payments are limited to professional earnings. My investment income is tax-exempt because I buy Municipal Bonds."

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CONTINUATION COURSES

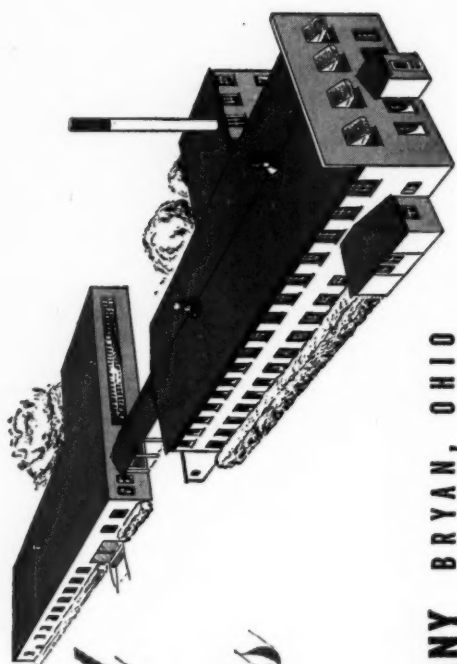
Therapy of Cardiovascular Diseases.—The University of Minnesota will present a continuation course on therapy of cardiovascular diseases February 1 to 16. The course is intended especially for general physicians and will be presented at the Center for Continuation Study. Dr. Charles P. Bailey, professor of surgery, Hahnemann Medical College, Philadelphia, will be the visiting faculty member for the course. He will also give the annual Phi Delta Epsilon Lecture on the evening of Thursday, February 14. His subject at that time will be "Recent Advances and Future Trends in Cardiovascular Surgery." Dr. Bailey is well known

throughout medical circles for his work on surgery of rheumatic valvular heart disease. He will report on this work in a lecture in the continuation course.

Dermatology.—Dermatology will be the subject of a continuation course for general physicians to be presented by the University of Minnesota, February 28 to March 1. Dr. Arthur C. Curtis, professor and chairman of the Department of Dermatology, University of Michigan, will be the visiting faculty member for the course. The course will be presented under the direction of Dr. Henry E. Michelson, chairman of the Division of Dermatology at the University of Minnesota.

X-Ray for General Physicians.—The University of Minnesota will present a continuation course in x-ray

REPORTS AND ANNOUNCEMENTS



*Pharmaceutical
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for general physicians at the Center for Continuation Study on March 3 to 5. The course will be under the direction of Dr. Leo G. Rigler, professor and head of the Department of Radiology. Special emphasis will be placed on x-ray techniques, x-ray diagnosis of fractures, other bone lesions and pulmonary lesions. In addition to lectures on these subjects, practical demonstrations will be held. The registrants for the course will be invited to bring their own films to the course for discussion.

BLUE EARTH COUNTY SOCIETY

The Blue Earth County Medical Society held its annual meeting at Mankato on December 10 and elected the following officers: Dr. Robert B. Engstrom, president; Dr. John C. Mickelson, vice president, and Dr. William S. Chalgren, secretary-treasurer, all of Mankato. Dr. John C. Vezina, Mapleton, was named delegate to the Minnesota State Medical Association.

CLAY-BECKER COUNTY SOCIETY

Officers elected at the annual meeting of the Clay-Becker County Medical Society at Detroit Lakes on December 8 were as follows: Dr. V. D. Thysell, Hawley, president; Dr. A. S. Midthune, Lake Park, vice president, and Dr. William C. Dodds, Detroit Lakes, re-elected secretary-treasurer.

MOWER COUNTY SOCIETY

This year, 1952, is the fiftieth anniversary of the Mower County Medical Society. The society, which was founded on October 3, 1902, will be the sponsor this year of the annual meeting of the Southern Minnesota Medical Association to be held at Austin in September.

President of the society is Dr. L. F. Twiggs, with Dr. T. M. Seery as vice president and Dr. F. H. Rosenthal as secretary-treasurer, all from Austin.

RAMSEY COUNTY SOCIETY

New officers of the Ramsey County Medical Society, elected at a meeting in Saint Paul on November 26, are Dr. J. P. Medelman, president, succeeding Dr. F. G. Hedenstrom; Dr. P. F. Donohue, president-elect for 1953, and Dr. Laurence D. Hilger, re-elected secretary-treasurer. All are from Saint Paul.

RED RIVER VALLEY SOCIETY

At the annual meeting of the Red River Valley Medical Society at Crookston on December 11, the following officers were elected: Dr. M. D. Starekow, Thief River Falls, president; Dr. George S. Boyer, Crookston, vice president, and Dr. R. O. Sather, Crookston, re-elected secretary-treasurer. Dr. L. N. Dale, Red Lake Falls, was the retiring president.

Forty physicians attended the meeting, at which the main topic for discussion was the legal aspect of various medical problems. It was decided to appoint a committee to develop a code governing the relations of the medical profession with hospitals, the press and radio.

MINNESOTA MEDICINE

Woman's Auxiliary

PRESIDENT-ELECT REPORTS ON STATE PRESIDENTS CONFERENCE

Mrs. C. L. Sheedy
President-Elect

Attending the eighth annual conference of state presidents, presidents-elect and national committee chairmen is an exciting experience, especially when one is trying to land at the Chicago Airport with seven small tornadoes dancing in attendance. One just knew that, with such a stimulating beginning, this was no ordinary conference. It is a pleasure to meet at last, in person, these pen pals of ours who have spurred us on to such goals. When we talk to them and find them mindful of our problems, we realize how much effort and time they must spend to guide us in the right direction.

The conference will be reported in detail in *The Bulletin*, and Dr. Walter Judd's very fine speech will be distributed to the Auxiliary members, so I wish to tell you some of the thoughts left with us by Mr. Edward O'Connor, Managing Director of Insurance Economic Society of America, whose organization is devoted to the study of social insurance. He quoted Winston Churchill's statement, "Free enterprise has its faults, but it is much better than Socialism with its blessings of misery." Fortunately, sufficient people have come along and stressed a positive dislike for the further development of Socialism. We have gone so far down the path of hand-out state, he continued, that it is impossible to shoot Santa Claus, but I do believe we have begun to sober him up.

We are in a great epic struggle in this country. It is not the old-time contest between the Republicans and Democrats, or what political system works better; it is not a struggle to make democracy work, but to destroy it, not to make it equitable and beneficial to all, but to substitute a system entirely different from that which we have lived and prospered under for one hundred and fifty years.

This situation exists because we have all been smug and complacent. We have taken our freedom for granted. We have assured ourselves that the United States is the greatest nation in the world, that we are God's chosen and that no evil can come to us. But, all of the time, we are being blinded by our own reflection, either being unwilling or unable to see that those things that could not happen here have actually happened. A whole generation has been taught that the world owes them a living; that the government can provide a job for everyone from the cradle to the grave, a doctor at your side and government pills when you are sick, a nice funeral when you die, a beautiful plot in the cemetery.

Our problem today is to help the public differentiate between true and false liberalism and get out of that dangerous habit of succumbing to propaganda, and

following the chant of the auctioneer. Propaganda is an art which has been fully developed in this country during the past twenty years. Its potency has been amply demonstrated in other lands.

The proponents of socialized medicine and sickness compensation never tire of beating the drums for their socialistic wares and never tire of subjecting the public to a barrage of twisted facts. They would destroy the most successful medical system the world has ever known and replace it with a system that has never worked anywhere. They fail to understand they cannot legislate health into being any more than you can create temperance by voting in the Volstead Act.

Mr. O'Connor closed by telling us that the freedom which we enjoy is not a permanent possession. It did not come as the result of a hand-out, nor is it self-perpetuating. Freedom is not free and it never was and never will be. It has a price tag: it requires eternal vigilance, alertness to expose every threat and to be prepared to fight those misguided individuals who would deprive us of our heritage in this country, which was built by men who relied on themselves.

We hold our destiny in our hands. There is a crooked and rocky road to slavery with its rosy promises and horrible realities and there is the straight road, the tried and proven road of freedom, the American way. We must make the decision. Do we want to be free people or slaves of the State? The hour is late, the time for action is NOW.

I am sorry not to be able to quote you the entire speech, but I am sure, with what little I have given you, you agree that Mr. O'Connor gave us much to reflect upon.

Needless to say how proud Mrs. Moersch, Mrs. Bakkila and I were of Mrs. Wahlquist, who always in her charming manner conducts with such enthusiasm and draws everyone into the spirit of her theme for this year, "Working Together for Health."

NICOLLET-LE SUEUR HOLDS MEETING

Dr. Burton P. Grimes, Superintendent of the St. Peter State Hospital, spoke on "Mental Health" at a luncheon meeting of the Nicollet-Le Sueur County Medical Auxiliary on October 15 in St. Peter, Minnesota. About thirty-five auxiliary members and guests heard Dr. Grimes' discussion of various aspects of mental health.

The personal attitudes of the patient are important in the treatment of any disease in which the patient's co-operation must be elicited. The more chronic the illness, the greater importance these personal factors assume. Osler summed up the situation in tuberculosis when he said, "It is just as important to know what is in a man's head as what is in his chest if you want to predict the outcome of his pulmonary tuberculosis."—JEROME HARTZ, M.D., *Public Health Reports*, October 6, 1950.

In Memoriam

A. W. ADSON

The following memorial to the late Dr. A. W. Adson, of Rochester, was incorporated in the report of the Council of Medical Service of the American Medical Association to the House of Delegates assembled in Los Angeles, California, in December, 1951.

MEMORIAL TO DR. A. W. ADSON

This report would not be complete without a word of appreciation of the services of Doctor Adson who was stricken while attending the North Central Conference in Minneapolis and died the following day, November 12, 1951.

In addition to his outstanding scientific attainments, he gave unstintingly of his time and energy to perpetuate and further the high standards of the medical profession.

Doctor Adson was a leader in the creation of the Council on Medical Service in 1943 and served on the Council from its origin until 1948. Part of that time he was its Vice Chairman and more recently he served as chairman of the Council's Committee on Prepayment Hospital and Medical Service.

He will be missed by all members of the Council, by the members of the House of Delegates, and by his many friends throughout the country who have had the privilege of his counsel and friendship.

JAMES R. MCVAY, *Chairman*

MR. THOMAS A. HENDRICKS, *Secretary*

GEORGE CHARLES BRUTSCH

Dr. G. C. Brutsch, of Minneapolis, died November 9, 1951, at the age of fifty. He was born in Ceylon, Minnesota, in 1900.

He was a member of the Class of 1931 of the University of Minnesota Medical School and had practiced in Minneapolis since his graduation.

He was a member of the Hennepin County Medical Society, the Minnesota State Medical Association and the American Medical Association.

Dr. Brutsch is survived by a brother, Elmer, of Estherville, Iowa, and four sisters.

AXCEL CONRAD BAKER

Dr. A. C. Baker, a physician for nearly fifty years at Fergus Falls, Minnesota, died December 7, 1951, at the age of seventy-seven.

Born in Rochester, Minnesota, September 28, 1874, he attended the University of Minnesota where he obtained a B.S. degree. His M.D. degree was obtained from Northwestern Medical School in 1901. He interned for two years at Wesley Hospital in Chicago.

Dr. Baker was a member of the Park Region District and County Medical Society, the Minnesota State Medical Association and the American Medical Association. He was also a Fellow of the American College

of Surgeons and had served as President of the Northern Minnesota Medical Association.

Dr. Baker is survived by his wife Kathryn H. Baker; two sons, Norman of Fergus Falls, Charles of Belle Fourche, South Dakota, both of whom are physicians, and two daughters, Kathryn (Mrs. Robert) Hyslop of Fergus Falls and Mary (Mrs. Harold) Mattlin of Colorado, California.

F. R. CROSON

Dr. F. R. Croson, formerly of Proctor, Minnesota, died on November 7, 1951.

Born at Aledo, Illinois, he received his medical education at Northwestern University Medical School, graduating in 1918. He was associated with Dr. Webber in the Missabe Hospital and was a member of the St. Louis County Medical Society during his stay in Minnesota.

Dr. Croson was at one time president of the Kansas State Medical Association and had practiced in Clay Center, Kansas, from 1925 until he retired from active practice last summer.

RALPH T. EDWARDS

Dr. Ralph T. Edwards, formerly of Elysian, Minnesota, died October 12, 1951, at Big Fork, Montana, where he had been living with a daughter since his retirement from active practice several years ago.

Dr. Edwards was born near Plymouth, Illinois, April 22, 1872. He attended Pomona College at Claremont, California, and graduated from Knox College, Galesburg, Illinois, with an M.A. degree in 1899. He graduated from Johns Hopkins medical school in 1904.

He was associated with the U. S. Bureau of Science at Manila from 1905 to 1908 and was Director of the Government's Serum Laboratory at Phrapatoom from 1908 to 1910. After practicing at Galesburg, Illinois, a year; at Warsaw, Illinois, a year; at Ceylon, Minnesota, three years; at Manila, three years, and in Siam, two years, he settled in Elysian, Minnesota, where his special interest was directed to Ophthalmology.

Dr. Edwards was a member of the Blue Earth County Medical Society, the Minnesota State Medical Association and the American Medical Association.

He is survived by two daughters, Mrs. Mary E. Jung, of San Diego, and Emma H. Edwards, of Big Fork, Montana; and one son, R. Stanley Edwards, of Chagrin Falls, Ohio.

EVERET FLOYD GRAVE

Dr. E. Floyd Grave, founder of the Medical Arts Clinical Laboratory in Minneapolis, died December 20, 1951, at the age of sixty-seven.

He was born in Monrovia, Indiana, August 13, 1884. He obtained a B.S. degree from Carleton College in 1908 and graduated from Johns Hopkins University in

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1914. He interned the following year at the City and County Hospital in Saint Paul. He took postgraduate training at Minnesota and Wisconsin State Universities in laboratory procedure and served as a major in World War I. He was pathologist at Asbury, St. Barnabas, Eitel and the Minneapolis Veterans Hospitals.

Dr. Grave was a member of the Hennepin County Medical Society, the Minnesota State Medical Association and the American Medical Association. In 1939 he was elected a fellow of the American Society of Clinical Pathologists.

Dr. Grave is survived by his wife, Katherine M., a daughter, Katherine Ann, and a brother, Thomas H. Grave, of Gresham, Oregon.

WALDO N. GRAVES

Dr. W. N. Graves of Duluth died on December 5, 1951, at the age of fifty-three.

Dr. Graves was born at Indianola, Iowa, February 26, 1898. He received an A.B. degree from the University of South Dakota in 1920 and completed his medical training at Rush Medical College where he received his M.D. in 1923. His internship was served at Cook County Hospital, Chicago. Three months of postgraduate work were spent at the University of Vienna.

Dr. Graves was associated for some seventeen months with Dr. Robert Emmett Farr of Minneapolis and for eighteen months with the Peabody Clinic at Webster, South Dakota.

Dr. Graves was a member of St. Louis County Medical Society, the Minnesota State Medical Association and the American Medical Association. He was a Fellow of the American College of Surgeons, the Interurban Academy of Medicine and the Duluth Surgical Society.

Dr. Graves was a veteran of both World War I and World War II, having served in the U. S. Navy.

He is survived by his parents, his wife and two children.

A. D. HASKELL

Dr. A. D. Haskell, well known physician of Alexandria for the past four decades, passed away December 2, 1951, at the age of seventy-four.

Dr. Haskell was born at Anoka, Minnesota, May 16, 1877. He obtained his M.D. degree from the University of Minnesota in 1900 and interned at the City and County Hospital (now the Ancker) in Saint Paul. He practiced at Carlos, Minnesota, from 1900 to 1910.

Married in Minneapolis in 1907, Dr. and Mrs. Haskell moved to Alexandria in 1910.

Always active in community affairs, Dr. Haskell served as mayor in 1937 and as a member of the city council and board of public works during his residency in Alexandria. He was president of the Park Region Medical Society in 1928 and was a member of the Minnesota State Medical Association and the American Medical Association.

Dr. Haskell is survived by his wife.

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RUSSELL ROBERT HENDRICKSON

Dr. R. R. Hendrickson of Crookston died December 18, 1951, at the age of forty-eight.

Dr. Hendrickson was born at Iron River, Wisconsin, August 17, 1903. He attended Eveleth High School and Eveleth Junior College. He obtained an M.D. degree at the University of Minnesota in December, 1927, and interned at St. Mary's Hospital, Duluth.

At one time Dr. Hendrickson served as medical officer for the St. Cloud reformatory. He practiced at St. Cloud from 1930 to 1938. He was at one time superintendent and medical director of Buena Vista Sanatorium at Wabasha, superintendent of Fair Oaks Lodge sanatorium at Wadena and of Sand Beach Sanatorium at Lake Park, near Detroit Lakes. During World War II, he was tuberculosis specialist for the U. S. Public Health Service in Alaska and served as chief of the tuberculosis service at the Marine Corps hospital in New York. He was medical director and superintendent of Sunny Rest Sanatorium at Crookston for nine months before his enforced retirement because of a heart ailment.

Dr. Hendrickson is survived by his wife, two sons, Russell J., and Jack, and a daughter, Mary Katherine.

OLAF KITTLESON

Dr. Olaf Kittleson, a native of Zumbrota township, Minnesota, died December 5, 1951, at Willmar, Minnesota, where he was a member of the medical staff at the State Hospital. He was sixty-four years of age, having been born July 13, 1887.

He attended the high school at Zumbrota and graduated from the University of Minnesota medical school in 1912. He was a fellow at the Mayo Clinic for two years and later served in World War I for three years.

Dr. Kittleson practiced medicine in Minneapolis and in Zumbrota before accepting a position at the Willmar State Hospital in February, 1951. He had never married.

THURSTON WILLIAM WEUM

Dr. Thurston William Weum, a specialist in obstetrics and gynecology in Minneapolis for more than thirty years, died on December 20, 1951, at the age of sixty-nine, after a long illness.

Dr. Weum was born in 1882 at Norcross, Minnesota, and attended school at Moorhead. He attended the University of Minnesota and the University of Chicago before obtaining an M.D. degree at Northwestern University.

He practiced medicine at Duluth and at South Haven, Minnesota, before locating in Minneapolis.

Dr. Weum was a diplomate of the American Board of Obstetrics and Gynecology and a fellow of the American College of Surgery. He was also a member of the Central Association of Obstetrics and Gynecology, the Hennepin County Medical Society, the Minnesota State Medical Association and the American Medical Association. He had been on the faculty of the Medical School of the University of Minnesota since 1918.

Dr. Weum is survived by his wife, Evelyn, and two daughters, Mrs. Marjorie Yench of New York and Audrey Weum of Milwaukee.

Of General Interest

In the Third Supplement of the United States Pharmacopoeia XIV, the definition of Liver Injection is changed to read:

"Liver injection is a sterile solution in water for injection of that soluble thermostable fraction of mammalian livers which increases the number of red corpuscles in the blood of persons affected with pernicious anemia. Each cubic centimeter of Liver Injection has a vitamin B₁₂ activity equivalent to either 10 or 20 micrograms of cyanocobalamin. The potency is not less than 100 per cent and not more than 150 per cent of that stated on the label.

"Liver injection may contain not more than 0.5 per cent of cresol or of phenol as a bacteriostatic agent."

Thus, liver injection in the future will be standardized so that the activity of one unit corresponds to that of one microgram of B₁₂. This change became official on January 1, 1952. Official preparations will have an activity of 10 or 20 micrograms per cubic centimeter.

Dr. Robert E. Gross, Ladd Professor of Children's Surgery at Harvard Medical School, will present the George E. Fahr lecture on "Coarctation of the Aorta" on April 8 at 8:15 p.m., at the amphitheater, Owre Hall (formerly Medical Sciences) at the University of Minnesota.

Dr. Marie K. Bepko, Cloquet, attended the third Congress of the Pan-American Medical Women's Alliance, Inc., at Montevideo, Uruguay, from December 2 to 8. The meeting was held in conjunction with the Pan-American Pediatric Society and the South American Pediatric Society. Tied in with the meeting was a tour which included visits to Rio de Janeiro, Buenos Aires, Santiago and Lima in South America and Port-of-Spain and San Juan, Puerto Rico. Dr. Bepko was away from Cloquet for about a month while on the tour.

Dr. Robert E. Priest and **Dr. William J. Kucera, Jr.**, are now associated at 302 Medical Arts Building, Minneapolis, in the practice of otolaryngology, laryngeal surgery and broncho-esophagology. Dr. Kucera, a graduate of the University of Minnesota Medical School, completed a three-year fellowship in otolaryngology at the University of Illinois on July 1, 1951. He is the son of **Dr. William J. Kucera, Sr.**, of Minneapolis.

After serving on the board of education at Wadena for eighteen years, **Dr. John S. Grogan** of Wadena resigned early in December. He stated that because of his duties with the Red Cross blood mobile unit he was unable to attend board meetings. During his years of service on the board Dr. Grogan was very active in developing school athletic facilities in Wadena.

Dr. Ralph T. Knight, Minneapolis, was elected president-elect of the American Society of Anesthesiologists at the annual meeting held at Washington, D. C., in November. Dr. Knight is a member at present of the board of directors and of the executive committee and will take office as president in November, 1952.

G. Ray Higgins, former director of students' unions at the University of Minnesota, was recently appointed executive secretary of the **Minnesota Heart Association**. Mr. Higgins has been director of students' unions for the past ten years.

It was announced on December 12 that **Captain Alexander M. Boysen**, a former Minnesota physician, had been listed by the Peking, China, radio, in a propaganda broadcast about treatment of prisoners, as being among the United States prisoners of war in Korea. Dr. Boysen was reported on July 12, 1950, as missing in action, and a few weeks later it was first reported that he was a prisoner of war. Minnesota Medicine has not yet heard whether his name was on the "official" lists released by the Reds later last month.

Dr. and Mrs. R. P. Michels, Willmar, returned home on December 6 from Chicago, where Dr. Michels took a week of postgraduate study.

Minnesota Blue Cross—Blue Shield is sponsoring Cedric Adams' "Dinner at the Adams'" half-hour radio show every Friday night from 7:00 to 7:30 p.m. over the WCCO-CBS station. This is the strongest and most influential station in the Northwest and will transmit information regarding these voluntary hospital and medical plans throughout the state.

Dr. Jan H. Tillisch, Rochester, has been appointed medical adviser to Mid-Continent Airlines. He has been a director of the company since 1949.

Dr. Allan J. Blake, Hopkins, has resigned as physician for the county home school for boys due to the demands of his private practice. He held the school post for the past two years.

The annual Phi Delta Epsilon lectureship at the University of Minnesota will be given in the auditorium of the University's Museum of Natural History at 8:15 p.m. on February 14. **Dr. Charles P. Bailey**, Philadelphia, will discuss "Recent Advances and Future Trends in Cardiac Surgery." All physicians and medical students are invited to attend.

Dr. Albert V. Stoesser and **Dr. Lloyd S. Nelson**, Minneapolis, have moved their offices from 1409 Wil-

OF GENERAL INTEREST

low Street to the LaSalle Building (Suite 616), located at Seventh Street and Marquette Avenue, Minneapolis. Their practice is limited to pediatrics and allergy.

* * *

It was announced in November that **Dr. Bernard S. Nauth**, Bagley, had resumed his practice at the Clearwater Clinic following a two-month absence. He is associated in practice with Dr. L. J. Larson.

* * *

Kenny Therapists.—Fifteen registered nurses and physical therapists from seven states and two foreign countries were awarded certificates as graduate Kenny therapists in the treatment of infantile paralysis in ceremonies at Westminster Presbyterian Church, Minneapolis, on December 19.

They were from a group of forty-eight trainees, the largest class to be in training as student Kenny therapists since the Kenny Institute, the Kenny Foundation's international Kenny therapist training center, was opened in Minneapolis in 1942. Thirty-three students are still in various phases of their training.

Designed to qualify trainees to become Kenny therapists, a new twenty-four-month course will be opened to registered nurses and physical therapists at Kenny Institute in June. Application blanks for Kenny therapist training scholarships for nurses and physical therapists are available by writing to the Director of Training, Sister Elizabeth Kenny Foundation, 1800 Chicago Avenue, Minneapolis, Minnesota.



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Marvin L. Kline, executive director of the Kenny Foundation, was principal speaker at commencement exercises for the 1951 class. Dr. Miland E. Knapp, chief of physical medicine in charge of therapist training for the foundation, presented the certificates.

The training of Kenny therapists consists of an intensive course in the Kenny concept and treatment of poliomyelitis. This specialized training is supplemented by courses in anatomy and physiology at the University of Minnesota Medical School. Students serve through two periods of polio incidence during their training course, which includes classroom instruction and work with polio patients. Before receiving a certificate, the trainee is given an opportunity to demonstrate ability to manage polio cases from admission to final discharge. Upon graduation, new fully-qualified Kenny therapists are assigned to one of the Kenny facilities in this country.

* * *

Dr. Elmer T. Cedar, Minneapolis, has been elected president of the Minnesota Dermatological Society.

* * *

Dr. R. A. Whitney, formerly of Cambridge, recently purchased a medical practice at Forsythe, Montana, and moved there to take it over about January 15. Dr. Whitney practiced medicine in Cambridge from 1938, except for a period during World War II when he was in military service.

* * *

Dr. Edgar J. Huenekens, Minneapolis, recently attended the Pan-American Pediatric Congress held at Montevideo, Uruguay.

* * *

Dr. Owen H. Wangenstein, chief of the University of Minnesota Department of Surgery, has been elected president of the Minnesota Academy of Medicine. Re-elected secretary of the organization is **Dr. Wallace P. Ritchie**, clinical assistant professor of neurosurgery.

* * *

Dr. Roger P. Hallin, Worthington, attended a one-day meeting of the Minnesota chapter of the American Academy of General Practice in Saint Paul in November. Dr. Hallin is associated with the Worthington Clinic.

* * *

"Surgical Lesions of the Adrenal Glands" was the title of a talk given by **Dr. J. T. Priestley**, Rochester, at a meeting of the Saint Paul Surgical Society on November 21.

* * *

Dr. Herman Linde, Cyrus, was the subject of a biographical feature story in the *Cyrus Leader* on November 15. Now practically retired, Dr. Linde has practiced at Cyrus since June, 1905. In addition to his practice, he has always been active in civic and community affairs.

* * *

Dr. Ruth Boynton, director of the student health service at the University of Minnesota, was the guest speaker at a meeting of the Woman's Auxiliary

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to the Hennepin County Medical Society in Minneapolis on January 4. The title of her talk was "Impressions of Great Britain."

* * *

Principal speaker at the first annual meeting of the nurses of Stearns County, held at Melrose on December 10, was **Dr. Robert N. Barr**, deputy executive officer of the Minnesota Department of Health. He discussed the advances made in fighting communicable diseases and described the problems now involved in diseases of the older age groups.

* * *

Dr. and Mrs. Charles H. Slocumb returned home to Rochester on November 14 after a two and one-half month trip to Europe. During the trip Dr. Slocumb, who is a consultant in the section on rheumatology at the Mayo Clinic and president of the American Rheumatology Association, spoke at several medical meetings and visited numerous hospitals.

* * *

On December 14 the board of regents of the University of Minnesota approved the appointment of **Dr. Robert B. Howard** as director of continuation medical education. Dr. Howard succeeds **Dr. George Aagaard**, who resigned on December 31 and became dean of Southwestern Medical School at the University of Texas.

Dr. J. D. Van Valkenburg was honored at a farewell party given by residents of Floodwood on December 30. Called back to service, Dr. Van Valkenburg left Floodwood on January 5 to become a major in the Air Force. He first began practice at Floodwood in 1936 and was there continuously, with the exception of four years which he spent in service during World War II.

* * *

At the annual staff meeting of the Mayo Clinic in Rochester on November 19, **Dr. J. W. Kernohan** was elected staff president, succeeding **Dr. Paul A. O'Leary**. Named as vice president was **Dr. L. T. Austin**, while **Dr. M. B. Coventry** was re-elected secretary.

The staff also approved a reorganization plan enlarging the clinic board of governors from nine to eleven members. The board was enlarged, it was said, to facilitate the handling of administrative problems of the steadily growing clinic. One of the new members named to the board is a physician, **Dr. M. W. Comfort**, a consultant in internal medicine at the clinic.

* * *

Dr. Roger L. J. Kennedy, Rochester, spoke on "Catholic Action" at a meeting of the Queen of Angels Holy Name Society in Rochester on December 9. Dr. Kennedy was recently honored by

OF GENERAL INTEREST

Pope Pius XII and given the title of Knight of St. Gregory for his religious and civic activities.

* * *

Dr. Hamlin Mattson, Minneapolis, has been invited by the board of the Swedish Surgical Society to present a paper on the surgery of inguinal hernia at a meeting of the society in Malmo-Lund, Sweden, April 25 and 26.

* * *

Dr. John F. Madden, Saint Paul, was recently elected to the board of directors of the American Academy of Dermatology and Syphilology.

* * *

Dr. Robert B. J. Schoch, Saint Paul city health officer, has been made a fellow of the American Public Health Association. The fellowship is bestowed for outstanding public health work. Dr. Schoch has held his present position in Saint Paul for seventeen years.

* * *

Dr. Jack Heimark, son of Dr. and Mrs. J. J. Heimark of Fairmont, has been awarded a three-year fellowship in internal medicine at the Mayo Foundation, Rochester. He is a recent graduate of the University of Minnesota Medical School.

* * *

Guest speaker at a meeting of the Quality Club and the ReVera Club at Redwood Falls on November 19 was Dr. P. B. Grimes, superintendent of the St.

Peter State Hospital, who described the care given patients and discussed needed improvements.

* * *

Dr. Stanley V. Lofness, Minneapolis, has joined the associate medical and surgical staff of St. Lucas Hospital at Faribault as consultant pathologist. He will be at the hospital on a part-time basis and will conduct regular clinical-pathological conferences for the staff members. Dr. Lofness is also associated with the Pathology Department of the University of Minnesota Medical School.

* * *

Dr. Francis G. Blake, wartime advisor to the President on problems of epidemic disease and former dean of the Yale Medical School, has been named civilian technical director of medical research in the office of the Army Surgeon General.

Dr. Blake will serve as expert consultant to Colonel John R. Wood, M.C., chairman of the Army Medical Research and Development Board, in the evaluation of current and proposed research projects conducted by Army medical installations and eighty-one co-operating civilian institutions. He will be responsible for ensuring close co-ordination between the Army's present \$10,079,000 medical research effort and similar programs sponsored by the other armed forces and civilian Federal agencies.

Dr. Blake is sixty-four years of age, a graduate of Dartmouth College and Harvard Medical School. He interned at Peter Bent Brigham Hospital in Boston and in 1917 was appointed assistant professor of medicine at the University of Minnesota.

* * *

It was announced during the middle of December that Dr. Norman J. Lee, Saint Paul, would become associated in practice with Dr. W. G. Workman at Tracy shortly after the first of the year.

* * *

Dr. M. J. McMahon, after twenty-five years of practice at Green Isle, has accepted a position on the medical staff of the St. Cloud Veterans Hospital.

* * *

New officers of the Minnesota and the Minneapolis chapters of the American Academy of General Practice have been announced. For the state chapter they are Dr. James A. Blake, Hopkins, president; Dr. Willis L. Herbert, vice president, and Dr. Alexander J. Ross, secretary-treasurer, both of Minneapolis.

Officers of the Minneapolis chapter are Dr. Herman E. Drill, Hopkins, re-elected president; Dr. E. G. Oppen, Minneapolis, re-elected vice president, and Dr. Louis J. Roberts, secretary-treasurer.

* * *

Open house was held on December 13 at a newly constructed clinic in Dawson, staffed by Dr. Vilhelm M. Johnson and Dr. George Boody. The one-story, modern designed building is divided into three suites for doctors, with additional rooms for x-ray, emergency surgery, laboratory and business office.

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Appointments to state boards were announced on December 31. Named a member of the Minnesota State Board of Health was **Dr. F. W. Behmler**, Morris, for a three-year term. **Dr. J. A. Bargen**, Rochester, was appointed to the Minnesota State Board of Medical Examiners to succeed the late **Dr. A. W. Adson**.

* * *

Special citations from the regents of the University of Minnesota were presented to two 1950 Nobel Prize winners, **Dr. Edward C. Kendall** and **Dr. Philip S. Hench**, both of Rochester, at a dinner at the University on November 29. Speakers at the ceremonies for the men who developed cortisone included President **J. M. Morrill** of the University and **Dr. Owen H. Wangensteen**, head of the Department of Surgery at the University.

* * *

HOSPITAL NEWS

Listed below are the results of recent staff elections at various Minnesota hospitals:

Blue Earth Community Hospital, Blue Earth.—**Dr. H. H. Russ**, chief-of-staff; **Dr. G. W. Drexler**, secretary-treasurer.

St. Luke's Hospital, Saint Paul.—**Dr. Donald C. Deters**, chief-of-staff; **Dr. Walter T. Brodie**, vice chief-of-staff; **Dr. John Farkas**, secretary.

St. Cloud Hospital, St. Cloud.—**Dr. F. H. Baumgartner**, chief-of-staff; **Dr. John F. Kelly**, vice president; **Dr. R. T. Petersen**, secretary.

Asbury Methodist Hospital, Minneapolis.—**Dr. Harold F. Wahlquist**, president; **Dr. Wayne H. Hagen**, vice president; **Dr. Karl D. A. Andresen**, secretary-treasurer.

County Hospital, Olivia.—**Dr. Chester A. Anderson**, president and chief-of-staff; **Dr. H. P. Hinderaker**, vice president; **Dr. M. B. Dahle**, secretary-treasurer.

St. John's Hospital, Saint Paul.—**Dr. C. Kenneth Cook**, president; **Dr. T. S. McClanahan**, vice president; **Dr. C. R. Tift**, second vice president; **Dr. F. J. Milnar**, secretary.

* * *

It was announced on December 20 that **Dr. William C. Heiam** is adding another addition to the **Cook General Hospital** at Cook. There will be space for five more beds and a children's room.

* * *

Two new laboratories—a \$180,000 installation—were opened at **Minneapolis Veterans Hospital** on December 12. One is a radioisotope laboratory and the other a surgical research laboratory. The research work being done in these new laboratories, together with the numerous other projects being conducted at the hospital, makes the **Minneapolis Veterans Hospital** the third largest research center in Minnesota.

* * *

The new superintendent of **Minneapolis General Hospital** is **Kenneth Holmquist**, former assistant

OF GENERAL INTEREST

superintendent at the University of Minnesota Hospitals. Mr. Holmquist is the first non-medical man to hold the post in the hospital's sixty-four years. He succeeded the late Dr. D. W. Pollard.

Although Mr. Holmquist is administrative head of the hospital, the medical staff has its own chief for professional decisions, Dr. Thomas Lowry. Shortly after taking over, Mr. Holmquist started the policy of holding administrative staff meetings each month, corresponding to the medical staff meetings, which he also attends.

BLUE CROSS-BLUE SHIELD

The Minnesota Blue Shield contract covering U. S. Steel employees which became effective August 1, 1951, contains uniform benefits throughout the nation for subscribers covered by this special contract, and therefore it was necessary to issue a separate schedule of payments to doctors which is titled "Schedule of Payments to Doctors of Medicine for Surgical and Obstetrical Group Contract S-1." The insert in this schedule lists the subsidiary companies affected by this schedule. On October 8, 1951, letters were sent to each participating doctor in Minnesota informing him of this new U. S. Steel schedule which was available upon request to this office. In this letter it was pointed out that most persons covered under this contract live in Duluth or on the Iron Range. In response to this letter, a rather general distribution of this schedule was made, as requested by the doctors or clinics.

During the interval since the effective date of the U. S. Steel contract, it appears that in some instances the doctor or his office assistant is under the impression that the schedule of payments to doctors for U. S. Steel employees replaced the standard "Schedule of Payments to Doctors of Medicine, M.S. 1-5-51." However, the standard schedule as revised May 1, 1951, still determines the amounts paid on all Blue Shield contracts except those subscribers covered under the Steel contract.

The allowances in the Steel contract are somewhat higher for some procedures. Under the Steel schedule some surgical items carry a payment of \$200.00 and obstetrical deliveries carry a \$60.00 payment. It should be pointed out that only surgical and obstetrical services are payable under the Steel contract. No allowances are included for medical care in the hospital, the home or the office, and further, ancillary services including x-rays, anesthesia and some endoscopic examinations are ineligible for payment as claims. The Steel Contract is not a service but a straight indemnity contract. The payments made by Blue Shield under this contract apply on the doctor's bill but are not necessarily full payment.

October, 1951, was the first month of Minnesota Blue Shield's four years of experience in which over 10,000 claims were processed. This October claim load of 10,348 represents a 60 per cent increase over the 6,009 claims processed in October of 1950. Of further interest in this regard is a comparison of subscriber enrollment in October of each year. In 1950, there were 385,512 subscribers while in October, 1951, there were 515,442 subscribers, an increase of approximately 7.5 per cent. Quite clearly this indicates a sharp increase in the number of claims per thousand contracts.

These claims and enrollment figures are given further emphasis by the cost of claims processed this year as compared with 1950. During October just passed, incurred claims cost amounted to \$323,208, whereas claims paid in October, 1950, amounted to \$227,729. Also the cost of claims paid during the first ten months of 1950 amounted to \$1,781,545, while claims cost for the same period of 1951 was \$2,567,017.

Blue Cross payment to hospitals for October was \$982,018, and to date this year \$9,399,204, compared with \$8,165,879 to date last year. During October, 10,141 participant subscribers were enrolled in Blue Cross bringing the total enrollment as of October 31, 1951, to 1,020,806.

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For some time Minnesota Blue Cross and Blue Shield Plans have felt the need of a broader and more personal contact with the general public. The need for better public relations and understanding of the part we play in our statewide community is genuinely felt, and because of the great pulling power of Cedric Adams, experienced during the past non-group campaigns we are now sponsoring Cedric Adams' own show, "Dinner at the Adams."

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Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting March 3, June 2.

Surgical Anatomy and Clinical Surgery, two weeks, starting March 17, June 16.

Surgery of Colon and Rectum, one week, starting March 3, April 7.

Gallbladder Surgery, ten hours, starting April 21. Basic Principles in General Surgery, two weeks, starting March 31.

Breast and Thyroid Surgery, one week, starting June 23.

Esophageal Surgery, one week, starting June 23.

Thoracic Surgery, one week, starting June 2. Fractures and Traumatic Surgery, two weeks, starting February 4.

GYNECOLOGY—Intensive Course, two weeks, starting February 18, March 17.

Vaginal Approach to Pelvic Surgery, one week, starting March 3, March 31.

OBSTETRICS—Intensive Course, two weeks, starting March 3, March 31.

MEDICINE—Intensive General Course, two weeks, starting May 5.

Electrocardiography and Heart Disease, two weeks, starting March 17.

Gastroenterology, two weeks, starting May 19.

Hematology, one week, starting June 16.

UROLOGY—Intensive Course, two weeks, starting April 28.

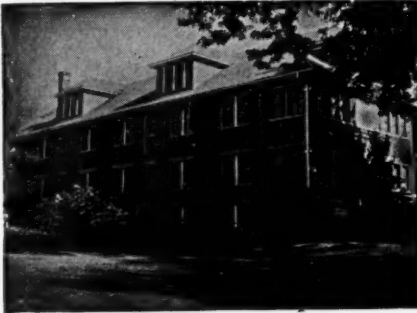
Ten-day Practical Course in Cystoscopy starting January 21, February 18, and every two weeks.

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New Farm Bureau \$25 Deductible Blue Cross Contract

As of January 1, 1952, a \$25 deductible clause will be attached to all Farm Bureau Blue Cross group contracts. Blue Cross has developed this \$25 deductible contract offering all Farm Bureau subscribers the most amount of benefits for a minimum rate, and yet maintaining the catastrophic coverage that Blue Cross has always given.

The fact that farmers and their families have used 110 per cent more Blue Cross benefits than they paid for accentuated the need of a \$25 deductible contract.

The \$25 deductible Blue Cross contract specifically geared to the needs of Farm Bureau members was adopted after careful study by Minnesota Blue Cross and the Farm Bureau Federation board members who long have been seeking a satisfactory answer to the task of giving farm bureau subscribers the most protection at a minimum rate.

The \$25 deductible feature for all Farm Bureau subscribers and their dependents will permit Blue Cross to offer seven dollars a day for room, board, and general nursing allowance in place of \$5 included under the present contract offered most Farm Bureau members,

plus full and complete service benefits for ancillary services included in the contract at no increase in rates.

When the Farm Bureau subscriber or one of his dependents is hospitalized, he will not be covered for the first \$25 of hospitalization. It is the subscriber's responsibility to meet his own hospital bill when the charge is twenty-five dollars or less. The \$25 deductible contract gives the Farm Bureau subscribers an opportunity to meet their own hospitalization when the cost is minor, and keeps intact the farmer's right to real protection when the hospital bill is catastrophic.

AIDS TO COMMUNITY HEALTH PLANNING

To help communities start new health councils—or make existing councils better—the National Health Council has prepared a new "loan kit" of health promotion literature. The kit, entitled "Aids to Community Health Planning," may be borrowed for a month at a time, with privilege of renewal, or purchased for \$2.50.

A health council is a planning and co-ordinating body of voluntary health groups, professional societies, official agencies and citizens' groups working together for community health. There are thirty-two state and 1,200 local councils in the country today, the National Health Council reports.

Divided into six sections, the kit contains more than a score of pamphlets, leaflets and reprints for the use of individuals and groups seeking to improve their community's health programs.

The material covers programs, activities, structure and financing of health councils. It includes sample constitutions and by-laws both for rural and urban councils and for health divisions of welfare councils.

For loan or purchase, write: National Health Council, 1790 Broadway, New York 19, New York.

BOOK REVIEWS

BOOK REVIEWS

Books listed here become the property of the Ramsey, Hennepin and St. Louis County Medical Libraries when reviewed. Members, however, are urged to write reviews of any or every recent book which may be of interest to physicians.

PATHOLOGY OF THE FETUS AND THE NEWBORN. Edith L. Potter, M.D., Ph.D. Associate Professor of Pathology, Department of Obstetrics and Gynecology, University of Chicago; Pathologist, Chicago Lying-in Hospital; Chief Pathologist, Chicago Department of Health. 574 pages. Illus. Price \$19.00, cloth. Chicago: Year Book Publishers, Inc., 1952.

PLASTIC SURGERY OF THE NOSE. James Barrett Brown, M.D. Professor of Clinical Surgery, Washington University School of Medicine, St. Louis, Missouri; Chief Consultant in Plastic Surgery, United States Veterans Administration, Washington, D. C.; formerly Senior Consultant in Plastic Surgery, U. S. Army and in E.T.O., and Chief of Plastic Surgery, Valley Forge General Hospital; and Frank McDowell, M.D., Assistant Professor of Clinical Surgery, Washington University School of Medicine, St. Louis, Missouri. 427 pages. Illus. Price \$15.00, cloth. St. Louis: C. V. Mosby Co., 1951.

BIOLOGICAL ANTAGONISM—The Theory of Biological Relativity. Gustav J. Martin, Sc.D. Research Director of the National Drug Co., Philadelphia. 516 pages. Illus. Price \$8.50, cloth. Philadelphia: The Blakiston Co., 1951.

SURGERY OF THE OBLIQUE MUSCLES OF THE EYE. Walter H. Fink, M.D., Minneapolis. 350 pages. Illus. Price \$8.75, cloth. St. Louis: C. V. Mosby Co., 1951.

ANNUAL REPORT ON STRESS. Hans Selye, M.D., Ph.D. (Prague), D.Sc. (McGill), F.R.S. (Canada). Professor and Director of the Institut de Medicine et de Chirurgie experimentales, Universite de Montreal. 511 pages. Illus. Price \$10.00, cloth. Montreal, Canada: Acta, Inc., 1951.

THE APHORISMS OF DR. C. H. MAYO AND DR. W. J. MAYO. Collected by Fredrick A. Willius, M.D. 109 pages. Illus. Price \$2.75, cloth. Springfield, Illinois: Charles C Thomas, 1951.

ANTIBIOTIC THERAPY. Henry Welch, Ph.D., Director, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of United States Government; and Charles N. Lewis, M.D., Medical Officer, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of United States Government; foreword by Chester S. Keefer, M.D., Wade Professor of Medicine, Boston University School of Medicine, Chairman, Committee on Medicine, and Chairman, Committee on Chemotherapy of the National Research Council. 562 pages. Illus. Price \$10.00, cloth. Washington, D. C.: The Arundel Press, 1951.

THE TEMPOROMANDIBULAR JOINT. Bernard G. Sarnat, M.S., M.D., D.D.S., F.A.C.S. Professor and Head of Department of Oral and Maxillofacial Surgery, College of Dentistry, Clinical Assistant Professor, Department of Surgery (Plastic Surgery), College of Medicine, University of Illinois, Chicago; Diplomate of the American Board of Plastic Surgery. 148 pages. Illus. Price \$4.75, cloth.

PENICILLIN DECADE, 1941-1951. Lawrence Weld Smith, M.D. Medical Director Commercial Solvents Corporation; and Ann Dolan Walker, R.N., former editor "Trained Nurse and Hospital Review." 122 pages. Price \$2.50, cloth. Washington, D. C.: The Arundel Press, 1951.

UNTOWARD REACTIONS OF CORTISONE AND ACTH. Vincent J. Derbes, M.D., F.A.C.P. Associate Professor of Medicine, Tulane University of Louisiana School of Medicine; Head of Department of Allergy, Ochsner Clinic; Visiting Physician Charity Hospital of Louisiana at New Orleans, and Staff Member, Foundation Hospital, New Orleans; and Thomas E. Weiss, M.D., Instructor in Medicine, Tulane University of Louisiana School of Medicine; Member of Department of Medicine, Ochsner Clinic; Visiting Physician Charity Hospital of Louisiana at New Orleans and Staff Member Foundation Hospital, New Orleans. 77 pages. Price \$2.25, flexible binding. Springfield, Illinois: Charles C Thomas, 1951.

DIABETES CONTROL. By Edward L. Bortz, M.D. Associate Professor of Medicine, University of Pennsylvania; Past President, American Medical Association. 264 pages. Price \$3.50. Philadelphia: Lea and Febiger, 1951.

This is a manual written primarily for the diabetic patient. The first few chapters are devoted to improving morale of the diabetic patient as well as general instructions. The chapter on care of the feet is exceptionally good. A long chapter on meal planning makes use of



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BOOK REVIEWS

the food exchange lists as adopted by the Committees of the American Diabetes Association and the American Dietetic Association. This new information gives to the patient a much wider choice of foods and an easier method of computing his diet. This new system has been adopted by the dietetic departments of many hospitals. This chapter alone is worth the price of the book.

The chapter on insulin covers N.P.H. insulin and the new insulin syringes. A chapter on weight control is valuable to the obese, whether diabetic or not.

The last chapter is a list of questions and answers.

It covers all phases of diabetes in simple language printed in easily read type on fine paper.

It is a valuable book for the diabetic patients, especially those who have received instructions from dietitians who are using the new food "exchange" system. It is a worthwhile addition to a physician's library.

LLOYD L. MERRIMAN, M.D.

LOW-SODIUM DIET. A MANUAL FOR THE PATIENT. By Thurman B. Rice, A.M., M.D. Professor of Public Health, Indiana University School of Medicine, Indianapolis, Indiana. 103 Pages, 14 Food Charts. Price \$2.75. Philadelphia: Lea & Febiger, 1951.

The low sodium diet, as such, is mighty difficult to follow due to its extreme unpalatability and limitations. As a result, the average person when confronted with the prospect of having to follow this extremely restricted diet many times will think, "Well, what's the use?"

The information which is given in Dr. Rice's book is particularly aimed at the average person with an average amount of knowledge and understanding. He tells why sodium is important in the diet, where it can be found, which foods to eat, and which to omit. There is one chapter on possible ways of varying the diet and relieving the monotony, and the problem of "eating out." He discusses foods that have hidden sodium in them due to processing. There are several chapters on actual samples of low-sodium diets and food charts indicating sodium content, et cetera.

In general, this book can be considered a good valid source of information. It explains in greater detail than the doctor or dietitian can take time to explain the important aspects of this particular modified diet.

ADELINE V. PAULSON

STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS. Fourth Edition. American Medical Association. 1034 pages. Price \$8.00. Philadelphia: Blakiston Co., 1952.

On January 2, 1952, the American Medical Association made available to hospitals the new fourth edition of Standard Nomenclature of Diseases and Operations.



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Revision of this useful book has been under way intensively for the past three years starting with the decision to revise made at the Fifth National Conference on Medical Nomenclature held at the Association Headquarters office in June, 1948. Revision of the book was carried out by the editors under the general supervision of an Editorial Advisory Board and in collaboration with twenty-four committees representing each of the individual or specialty sections of the book.

Since its inception under the auspices of the New York Academy of Medicine, and the First National Conference on Medical Nomenclature in 1928, and the subsequent transferral of responsibility for its periodic revision to the American Medical Association in 1937, the "Standard Nomenclature" has grown rapidly to become the standard, and thereby the most acceptable system for the diagnostic coding of hospital records for more than seventy per cent of U. S. Hospitals. Although the dual topographic-etiological coding system is not uncomplicated, it has many times over demonstrated its flexibility both through ease of simplification for the

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BOOK REVIEWS

small hospital, and in ready expansibility for the large teaching and research hospital.

Because of the wide acceptance of this coding system, and the fact that hospital record systems using "Standard" must make the changes provided for in each revision, the editors of the Fourth Edition have made every effort to avoid changes that are not strictly required. Nevertheless, the rapidly expanding scientific knowledge in many fields in recent years has required a considerable number of changes in several sections of the book. These have included a complete revision of the Psychobiologic section to bring it into accord with accepted diagnostic terminology of the American Psychiatric Association, a complete revision of the diseases of the Hemic and Lymphatic section to accord with newer thought in this field, and a complete revision of the section on tumor etiology. Changes in the nomenclature and coding of tumors comes about as a result of the deliberations of the "Standard" Committee on Oncology with similar committees of the American Cancer Society, the National Research Council, the U. S. National Committee on Health and Vital Statistics, American Society of Clinical Pathologists, Armed Forces Institute of Pathology, U. S. Public Health Service and others, all of whom have adopted the new nomenclature.

For purposes of a closer identification of two systems, the Fourth Edition of Standard has included an appendix cross reference of "Standard" code numbers to code numbers of the "International Statistical Classification of Diseases, Injuries and Causes of Death."

The "International" code numbers have also been included parenthetically in the Nomenclature section of the book. The main purpose of this has been to simplify the work of hospitals who do, or may wish to, participate in or contribute toward large-scale state, nation, or world statistical studies of disease incidence. It must be emphasized however, that for purposes of hospital recording, the systems are by no means interchangeable. The "Standard" system, as a clinical system, is necessary for the proper separation of individual differences in diseases for recording and research purposes, whereas the "International" system applies mainly to much broader disease groupings for statistical purposes. Thus, one code number in the International list may be used to represent twenty or more conditions classified and coded separately in the "Standard Nomenclature."

In view of the fact that the "International List" is now accepted on a world basis for statistical analyses by the countries participating in the World Health Organization, and the fact that the cross coding to "Standard" has been a tremendously detailed and time-consuming work, it seems pertinent to now suggest that the combined systems, clinical and statistical, may be an appropriate consideration for the World Medical Association for sponsorship or adoption in either the present or next succeeding revision.

Unquestionably, the adoption of "Standard" in the hospitals of this country not now using it can be an effective and needed move toward the unity inherent in calling the same things by the same names.

RICHARD J. PLUNKETT, M.D.

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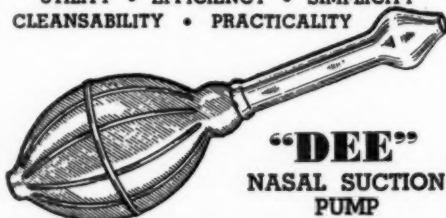
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MEDICAL TERMINOLOGY MADE EASY. Je-
Harned, R.N., R.R.L., Instructor in Medical Record
Library Science and Medical Record Librarian, Duke
University School of Medicine and Hospital, Durham,
N. C. 275 pages. Price \$5.00. Chicago: Physicians'
Record Company, 1951.

Written by a person well qualified for the task, this book is primarily an easy-to-read textbook on medical terminology, with special emphasis on the jargon used by physicians and nurses in their speech and in writing hospital records. As the author states, it is not a substitute for a medical dictionary but is intended to introduce beginners in various types of medical work to the specialized language used in the field of medicine. The book is aimed mainly at hospital administrators, pre-

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BOOK REVIEWS

medical and first-year medical students, nurses, medical librarians, technicians, therapists and secretaries.

Every profession or trade, the author points out, has its jargon, which, strange as it may sound to outsiders, is actually, in its own field, "more precise and less liable to errors of interpretation than ordinary English." This, of course, is because a jargon word is coined for a specific thing or act existing or done only under certain circumstances.

In this book, after a general discussion of the subject, the author plunges into an explanation and listing of medical prefixes and pseudo-prefixes, suffixes and pseudo-suffixes, and word stems, in each case giving an example of correct usage. Although etymology can often be dull, except to enthusiasts in the field, the author manages to make these sections of her book not only clear but interesting.

Following this, there is a chapter consisting of selected medical words and phrases (with definitions), based upon the various anatomical systems. Named are the anatomical parts of each system and diseases and pathologic conditions of each system.

The next chapter consists of an alphabetical list of terms commonly used in medical case records. With each word is a brief definition as well as an example of correct usage in a sentence.

There is also an excellent chapter on abbreviations and symbols, which, the author naturally emphasizes, are very important because of the time and space they save in the preparing of medical records and hospital charts. Because of the fact that many abbreviations are purely "local" ones and not in general use, the author divides the abbreviations into three categories and indicates which ones (1) are found in textbooks and dictionaries, (2) are in general use and might be approved in the future, (3) are not approved and are used only in certain locales.

An extremely thorough index completes the book.

All in all, although this book would be of little value to most physicians, it is well suited for those persons (named above) for whom it is intended. In addition, it would make an ideal and practical gift for a physician to present to a son or daughter who is planning to enter either the medical or nursing professions.

—J.H.L.

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METABOLISM

Beginning publication in January, 1952, a new journal will appear bi-monthly under the title of *Metabolism, Clinical and Experimental*. Dr. Samuel Soskin, Director of the Medical Research Institute at the Michael Reese Hospital, Chicago; Dean of the Michael Reese Hospital Postgraduate School, and Associate Professor of Medicine at the Northwestern University Medical School, is Editor-in-Chief. Dr. Fuller Albright, Associate Professor of Medicine at the Harvard Medical School, Boston, has the title of Consulting Editor.

Among the sixteen Associate Editors are Dr. Ancel Keys and Dr. Irvine McQuarrie of the University of Minnesota.

The new journal promises to be rather broad in scope, presenting material both clinical and experimental in nature and providing articles of interest to the general practitioner as well as the specialist and research worker.

Metabolism will contain original articles, abstracts of current literature, editorial discussion, book reviews, clinical reports of a summary or review nature and case reports.

Subscription price is \$9.00, payable to the publisher, Grune and Stratton, Inc., 381 Fourth Avenue, New York 16, New York.

DIABETES

A new journal, *Diabetes*, the journal of the American Diabetes Association, will appear bimonthly, beginning with the January-February, 1952, issue. It will be devoted to clinical and research reports on diabetes and related aspects of medicine. It will replace the association's annual proceedings and its quarterly *Diabetes Abstracts*, which have been published for the past ten years.

Diabetes will be edited by Dr. Frank N. Allan of the Lahey Clinic, Boston, with the assistance of an editorial board headed by Dr. Charles H. Best of the University of Toronto.

Members of the association will receive *Diabetes* free. The subscription rate for non-members will be \$9 per year. The editorial office is *Diabetes*, American Diabetes Association, Inc., 11 W. 42nd Street, New York 18, N. Y.

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